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TRUSTING JUDGES: A SOCIO-LEGAL INQUIRY ABOUT ACCESS TO HEALTH CARE VIA LITIGATION IN BRAZIL

Thesis submitted to the Faculty of Law at the University of Oxford for the degree of Doctor of Philosophy

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ABSTRACT

In 1988, the Brazilian Constitution enshrined in its text the right to universal health care, which formed the basis of the public health system, SUS. However, since the 90s the country observed an increasing trend of citizens starting legal action against the State to get access to drugs, treatments and medical devices not offered by SUS. The stark increase in successful health care cases is today a source of major concern. Against this backdrop, this thesis aims to understand what are the main socio-legal factors that influence the rise of successful litigation for access to health care in Brazil.

To answer this question, the thesis provides an in-depth analysis of qualitative empirical data about health care litigation in Brazil, based on semi-structured interviews with 55 actors – with a particular focus on judges and litigants.

The main outcome of the research is a middle-range theory about the links between internal and external socio-legal factors that influence the rise of successful health care litigation in Brazil. The thesis argues that there is a complex socio-legal web which combines various types of factors. A central factor which influences judges to grant health care claims is a deep-sited distrust in the quality of the health care public policy and the policy maker, aligned with an individual self-empowerment and tendency to altruism. The result is an attenuated form of judicial activism which uses the substantive constitutional law as a hindsight justification for granting claims. In parallel, a utilitarian trust in the positive outcome of legal action and low costs of litigating incentivises litigants to start legal action against the state. These various factors are analysed in the context of a post-colonial society, where citizens' individualist approach to the state, and the commodification of health incentivise the multiplication of individual litigation for access to health care.

To the more than 616,000 Brazilians whose lives were lost to Covid-19.
May our country be, one day, a place where no one needs to litigate for a healthy life.

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ABREVIATIONS

Agência Nacional de Vigilância Sanitária [National Health Surveillance Agency]	ANVISA
Comissão Nacional de Incorporação de Tecnologias no Sistema Único de Saúde [National Committee for Health Technology Incorporation]	CONITEC
Conselho Nacional de Justiça [National Justice Council]	CNJ
Relação Nacional de Ações e Serviços de Saúde [National List of Health Actions and Services]	RENASE
Relação Nacional de Medicamentos Essenciais [National List of Essential Medications]	RENAME
National Health Service in the UK	NHS
Sistema Único de Saúde [Unified Health System]	SUS
Superior Tribunal de Justiça [Superior Court of Justice]	STJ
Supremo Tribunal Federal [Federal Supreme Court]	STF
United Kingdom	UK
United Nations	UN
World Health Organization	WHO

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UNITED KINGDOM

BRAZIL

Supreme Court

Superior Court of Justice

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CHAPTER 1 - INTRODUCTION: THE RELEVANCE OF SOCIO-LEGAL FACTORS IN THE INCREASE OF SUCCESSFUL HEALTH CARE LITIGATION IN BRAZIL

Irrespective of age, gender, socio-economic status or ethnic background, health is undoubtedly one of the most crucial human attributes. Health is a fundamental human right, recognised by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Universal Declaration of Human Rights (1948)[1]. In article 12(1), the Covenant provides 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'[2].

The Brazilian Constitution of 1988 recognises the right to health as a fundamental socio-economic right. It provides, in article 196, that

> Health is a right of all and a duty of the state and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the *universal* and *equal* access to actions and services for its promotion, protection and recovery. [3] (emphasis added)

Whilst the promise of universal health[4] provided for in the article 196 of the Brazilian Constitution, is one of the 2030 sustainable development goals set by the United Nations[5], it is not by any means an easy task for governments to fulfil. Offering universal health care

[1] Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217 A(III) (UDHR) article 25

[2] International Covenant on Economic, Social and Cultural Rights 1966 (adopted 16 December 1966, entered into force 23 March 1976 article 12 (1)

[3] Article 196, Federal Constitution 1988, Brazil (available at https://english.tse.jus.br/arquivos/federal-constitution, accessed on 25/10/2021).

[4] Universal health coverage is understood as encompassing three simultaneous components (i) population covered by the health system, (ii) range of medical services available (including drugs, treatments and medical devices); and (iii) financial protection from the costs of health care services (Mark PEARSON, Francesca COLOMBO, Yuki MURAKAMI *and others*, *Universal health coverage and health outcomes* (2016)

[5] Audrey R CHAPMAN, 'Assessing the universal health coverage target in the sustainable development goals from a human rights perspective' (2016) 16 BMC international health and human rights 33

coverage requires high public investments[6] and a sound public policy able to deal with limited resources[7]. Most of the times this means having to make the tragic choices[8] that leave expensive treatments unavailable to the wider public.

The tension between the constitutional promise of universal health care coverage and the limits of fulfilling a universal health care policy very often reaches the courts. Individual and collective lawsuits filed against governments requesting access to health care can be identified throughout the world – from Latin America[9] to the United Kingdom[10], India[11] to South Africa[12]. And there is no shortage of legal analysis about it[13].

In Brazil, health care litigation is a major concern for academics, courts, and policymakers[14] due to the high numbers of lawsuits filed each day in courts requesting access

[6] Worawan CHANDOEVWIT, 'Financing universal health-care coverage' (2005) 20 TDRI Quarterly Review 14

[7] Peter J NEUMANN and Magnus JOHANNESSON, 'From principle to public policy: using cost-effectiveness analysis' (1994) 13 Health Affairs 206

[8] '[A] tragic choice cannot be precisely and exhaustively defined; however, it can be elucidated. Distributions of scarce goods that entail "great suffering or death," Calabresi and Bobbitt explain, "arouse emotions of compassion, outrage, and terror," which reveal conflicts between, on the one hand, the source of the scarcity and the values used to determine the recipients of the scarce good and, on the other hand, "those humanistic moral values which prize life and well-being"' (Barry HOFFMASTER and Cliff HOOKER, 'Tragic choices and moral compromise: the ethics of allocating kidneys for transplantation' (2013) 91 The Milbank quarterly 528)

[9] As an example of health care litigation in Latin America see: Everaldo LAMPREA, 'Colombia's right-to-health litigation in a context of health care reform' (2013) The Right to Health at the Public/Private Divide: A Global Comparative Study, Aeyal Gross and Colleen Flood, eds, Cambridge University Press, Forthcoming ; Peter LITTLEJOHNS, Albert WEALE, Kalipso CHALKIDOU *and others*, 'Universal health coverage and litigation in Latin America' (2012) Journal of Health Organization and Management ;

[10] Keith SYRETT, 'Impotence or Importance-Judicial Review in an Era of Explicit NHS Rationing' (2004) 67 Mod L Rev 289

[11] Ottar MÆSTAD, Lise RAKNER and Octavio L Motta FERRAZ, 'Assessing the impact of health rights litigation: a comparative analysis of Argentina, Brazil, Colombia, Costa Rica, India and South Africa' (2011) Litigating health rights: Can courts bring more justice to health 273

[12] Ebenezer DUROJAYE, *Litigating the Right to Health in Africa* (Ashgate 2015)

[13] For example, on the use of constitutionalism in health care litigation: Elizabeth Weeks LEONARD, 'State constitutionalism and the right to health care' (2009) 12 U Pa J Const L 1325 and Mark TUSHNET, 'Social welfare rights and the forms of judicial review' (2003) 82 Tex L Rev 1895. On the issue of judicial activism and judicial review in health care cases: Rodrigo M NUNES, 'Ideational origins of progressive judicial activism: The Colombian Constitutional Court and the right to health' (2010) 52 Latin American Politics and Society 67César RODRÍGUEZ-GARAVITO, 'Beyond the courtroom: The impact of judicial activism on socioeconomic rights in Latin America' (2010) 89 Tex L Rev 1669

[14] As an example, Octávio Luiz Motta FERRAZ, *Health as a Human Right: The Politics and Judicialisation of Health in Brazil* (Cambridge University Press 2020) and Daniel Wei Liang WANG, 'Courts as healthcare policy-makers: the problem, the responses to the problem and problems in the responses' (2013)

to drugs, treatments and medical devices not provided by the national health care system, the *Sistema Único de Saúde* (SUS)[15]. For instance, from 2008 until 2018, over 2,5 million cases filed in Brazilian courts were health care related[16]. Of these, more than 70% referred to access claims filed against the public health care service and private insurance companies, and only 2.7% referred to medical negligence claims[17]. That means that in that period there was roughly one health care related lawsuit for every 100 citizens in the Brazilian Judiciary. Furthermore, from 2008 to 2017, the number of lawsuits for access to health care skyrocketed, seeing an increase of 130%[18]. 70% of these cases sought to get an order from the Judiciary to compel the public authorities or private health insurances companies[19] to provide drugs, medical devices and treatments not available to the litigants[20]. In 2019, almost 475,000 new cases litigating the right to health care were filed in Brazilian courts[21].

It is worth noting that the large size of Brazil and the fragmentation of the judicial system – which is explained further below in section 1.2 – make it difficult to obtain accurate data about the numbers involved in health care litigation, especially in relation to municipalities. The literature often points to inconsistencies in the numbers reported by courts[22]

[15] The Unified Health System (SUS) is a health care system created in 1988 and which aims to provide Universal Health Coverage (UHC) for Brazilians. It is further explained in section 1.1 below

[16] In 2018, the National Council of Justice (CNJ) commissioned a research about health care litigation in Brazil. This in-depth research was conducted by INSPER (Instituto de Ensino e Pesquisa) and resulted in a report published in 2019. It focuses primarily on quantitative analysis of health care litigation. The research analysed over 700,000 cases from the first degree and appellate courts published between 2008 and 2018, and gives an insightful overview of the current situation of health care litigation in Brazil. (Paulo Furquim DE AZEVEDO, Fernando ABUJAMRA and et ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução* (Justiça Pesquisa, 2019)

[17] Ibid

[18] Ibid

[19] Is worth noticing that the health care system in Brazil is a single universal system comprised of the public service provided by SUS and *supplemented* by private health insurance companies, which are heavily regulated by the National Supplementary Health Agency (ANS).

[20] DE AZEVEDO, ABUJAMRA and ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução*, pg. 70.

[21] Conselho Nacional de Justiça (CNJ), *Justiça em Números* (2019)

[22] FERRAZ, *Health as a Human Right: The Politics and Judicialisation of Health in Brazil*, and DE AZEVEDO, ABUJAMRA and ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução*

due to, for instance, methodological discrepancies when indexing cases (i.e., cases which request drugs and treatments are sometimes indexed as 'medication' or 'medication/treatment'). Furthermore, often litigants request several drugs and devices at once, which makes it difficult to determine with certainty the most litigated medication. Nonetheless, even if estimated, the numbers present here are used to give an idea about the scale of the health care litigation in Brazil, as I do not intend to offer a quantitative analysis of the phenomenon.

This massification[23] of health care litigation is a burden not only to courts, which become overloaded, but to the public health care administration itself. For instance, the multiplication of individual litigation against SUS has had a profound impact on the public budgetary system and the management of the health care policy by the Executive. The Brazilian Ministry of Health estimates that in 2017 out of the R$125 billion (circa £20 billion) destined to fund the public health system, R$7 billion (circa £1.5billion) were spent on complying with judicial decisions[24].

So, what are Brazilian litigants pursuing when they sue the state for *access to health care*? The answer to this question is, it depends. Litigants can file lawsuits against the government mainly asking for drugs, treatments and/or medical devices (i) included in the health care public policy, but not available in public pharmacies or hospitals; (ii) not included in the health care public policy, although approved by the National Health Surveillance Agency, ANVISA[25]; and (iii) not included in the health care public policy *and* not approved by ANVISA.

[23] By massification I refer to the multiplication of individual claims with similar scope. The issue of mass and repetitive litigation is widely explored in the legal literature with regards to tort cases, class actions and joinder mechanisms (Edward H COOPER, 'Mass and Repetitive Litigation in the Federal Courts' (1986) 38 SCL Rev 489; Byron G STIER, 'Resolving the Class Action Crisis: Mass Tort Litigation as Network' (2005) Utah L Rev 863).

[24]Available at http://www.saude.gov.br/noticias/agencia-saude/25275-ministro-da-saude-fala-sobre-impacto-de-acoes-judiciais-no-sus

[25] The Brazilian Health Regulatory Agency (henceforth, ANVISA) is an autarchy linked to the Ministry of Health. It is part of the Brazilian national health care system (SUS) and responsible for the protection of the population's

In the first case, where the request involves drugs, treatments or medical devices which *are* already included in the public health care policy but are denied to the patient due to a shortage of supply, the litigation is a clear example of judicial control of the administrative act's legality (i.e., the public health care system denying a drug which is included in the policy and was prescribed by a public or private medical doctor)[26]. However, in the second and third cases, where the Judiciary is asked to decide cases requesting access to drugs, treatments and devices not included in the public policy, the limits of judicial review are less clear. Whilst some argue that the Judiciary should defer to the technical decision of the administrative authority, such as the Ministry of Health Care and ANVISA, thus limiting the scope of its review to the legality or constitutionality of the administrative act, the outcome of health care claims in Brazil seems to show a different picture. Moreover, it is estimated that over 80%[27] of health care lawsuits are successful and result in the immediate delivery of the drug or treatment to the litigant, even when such medication or treatment is not included in the public policy.

The lack of an express constitutional or statutory provision limiting the scope of judicial review (both of constitutionality and legality) in Brazil leaves judges free to exercise their reviewing power. However, the decision to grant drugs, treatments and medical devices not included in the health care policy is not just the result of an undefined statutory limitation to judicial review in Brazil. Moreover, as Ewick and Silbey note, 'legality is an emergent feature

health by executing sanitary control, including related environments, processes, ingredients and technologies, as well as the control in ports, airports and borders.

[26] Brazil does not have separate, specialised administrative courts, such as the ones identified in Italy or France, or Germany, and there is no statutory provision limiting the scope of judicial review. Judicial review is conducted based on three main Constitutional articles: (i) article 5th, Section XXXV, which provides that 'the law may not exclude from review by *the* Judiciary any injury or threat to a right', (ii) article 5th, Section LXIX, which provides that 'a writ of security (*mandado de segurança*) shall be issued to protect a liquid and certain right not protected by habeas corpus or habeas data, when the party responsible for the illegality or abuse of power is a public authority or an agent of a legal entity performing governmental duties'; and (iii) Article 37, *caput*, which provides that 'the direct or indirect public administration of any of the Branches of the Union, States, Federal District and Counties, shall obey the principles of legality, impersonality, morality, publicity and efficiency'.

[27] In São Paulo, for example, over 80% of claims are successful either totally (around 70%) or partially (10%) – meaning that the litigant was awarded all his/her request, or just part of it, i.e., only one of the drugs asked for.

of social relations rather than an external apparatus acting upon social life'[28]. The multiplication of health claims and the willingness of judges to grant them are influenced by a number of socio-legal factors, inter-related in a complex web. My research focuses on untangling this web and understanding what are the main socio-legal factors influencing the rise of such litigation in Brazil?

In light of the observations made above, my focus is not to undertake an in-depth analysis of the formal law, but to understand how the actors involved in the phenomenon, both legal 'professionals' (people who deal with health care and law as part of their professional activities) and 'lay' persons (people who are involved in health care litigation but not legally trained or professionally involved with the sector) understand the law and act on it. And, more widely, how the colonial past and contemporary social context of Brazilian society influences the rise of successful legal claims that seek access to drugs, treatments and medical devices. This does not mean that I disregard or overlook the importance of the formal law in the context of health care litigation. On the contrary. My goal is also to understand *how* the formal law interacts with other sociological factors, thereby enabling a middle-range theory about factors influencing the rise of successful health care litigation in Brazil.

This socio-legal analysis of health care litigation permits to understand, for example, how litigants make sense of and use the law (otherwise known as their 'legal consciousness'), what sociological factors come into play in judge's decision-making process, and how third parties' interests, such as pharmaceutical companies, can influence the outcomes of litigation without directly participating in it. By placing the analysis in the wider setting of social relationships and structures of powers established in post-colonial countries - such as Brazil – the study of health care litigation also permits the comprehension of broader social issues. For example, it sheds light on how a history of social inequality (both economic and political),

[28] Patricia EWICK and Susan S SILBEY, *The Commonplace of law. Stories of everyday Life* (1998) 17

clientelism, and corruption has incentivised the development of an individualist society, which is detached from the public sphere and distrusting of the state and government institutions. I analyse how these institutional contexts and social structures influence the rise of successful litigation for access to socio-economic rights, such as health care, through use of a distinct rights-based constitutional narrative[29].

Furthermore, by examining health care litigation in Brazil from this socio-legal perspective I will be able to offer sociological accounts of connected legal themes. For example, I examine (i) how judicial activism is fuelled by an individual self-empowerment of judges – especially in the lower rankings of the Judiciary; (ii) how trust – specifically the distrust in the policy maker – influences perceptions of (a lack of) quality of the health care policy, and thus impact judges' decision to grant drugs not included in the policy; and (iii) how litigants' legal consciousness (particularly with a focus on the use of legality as a 'game'[30]) shapes a utilitarian relationship with courts and the legal system.

The health care litigation phenomenon in Brazil I includes a set of interconnected socio-legal factors, which I analytically divide into external and internal factors. This dynamic relationship between internal and external factors forms the basis of my socio-legal account of the health care litigation phenomenon.

Before talking about the methodology and how I analytically unpack the internal and external factors influencing health care litigation, I offer a brief contextual description of the public health care system in Brazil, and the impacts of mass health care litigation in it.

[29] By constitutional narrative I refer to the set of beliefs and values which underpin the interpretation and application of the constitutional law. The narrative, as part of a constitutional culture, thus provides guidance and constraint on the application of law. This topic will be further discussed in Chapter 6. On the theme of constitutional narrative, see Robert C POST, 'Fashioning the legal constitution: Culture, courts, and law' (2003) 117 Harv L Rev 4 and Robert COVER, 'Nomos and Narrative'(1983)' (1995) 97 Harvard Law Review 4

[30] EWICK and SILBEY, *The Commonplace of law. Stories of everyday Life*

1.1 The public health care system in Brazil – SUS

The Sistema Único de Saúde (SUS) is a unified health system created in 1990, in light of the 1988 constitutional provision which promised universal and egalitarian health care to all Brazilians (article 196). The constitutionalisation of the right to health care was the outcome of a successful 'sanitary movement' which aimed at transforming the health care system of the country[31].

The system was regulated by Law n. 8.080/90, creating a decentralised universal system funded by tax revenues and contributions from federal, state and municipal governments. All three levels of the state, municipal, state and federal governments, are jointly responsible for the fulfilment of the constitutional right to health care – which means that litigants can choose to sue any of the three levels of government for access to health.

SUS is structured in three main pillars. In general, primary health care, is mainly executed by the 5,570 municipalities around the country, and secondary and tertiary health care, provided by regional (state) and federal governments respectively – although some municipalities also offer secondary and tertiary services, and some primary care programmes are provided by the regional and federal governments. The Ministry of Health is responsible for the national policy which regulates the SUS, including the analysis of sanitary and health safety by the National Health Surveillance Agency ('ANVISA'), and the incorporation of medicines, services and health technologies to the lists of standardised medications ('Rename') and treatments ('Renase')[32], which is compiled by the National Commission of Technologic

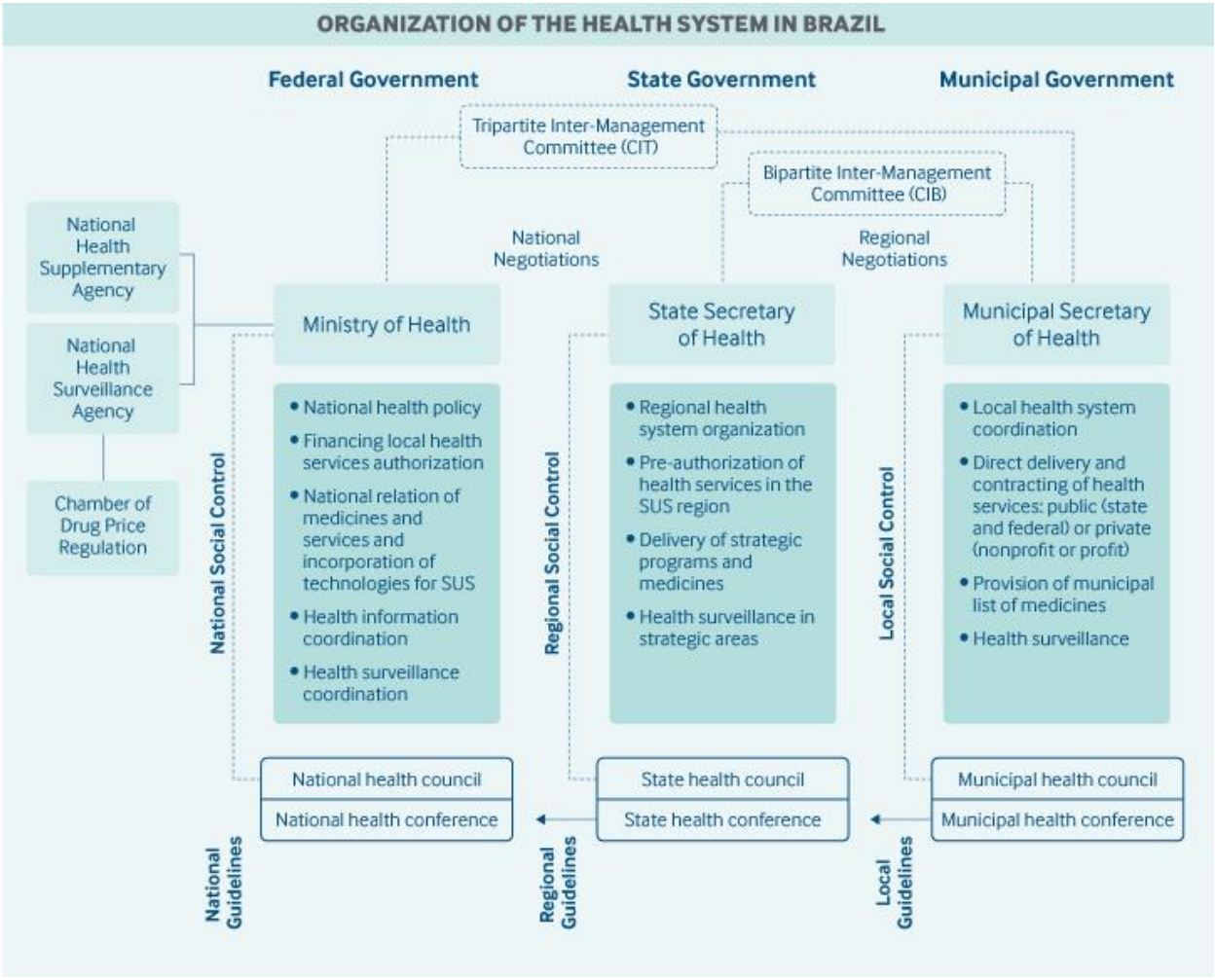
[31] FERRAZ, *Health as a Human Right: The Politics and Judicialisation of Health in Brazil*

[32] The National List of Essential Medicines (Rename) and the National List of Essential Health Actions and Services (Renase) define the basic drugs and treatments which should be offered in all the country. Municipalities can increase the lists of basic medicines and services by incorporating more technologies to the municipal lists (Remune).

Incorporation[33] ('CONITEC'). Therefore, to put it simply, in order for a health technology to be incorporated by the SUS and offered for free in public hospitals and pharmacies, it needs to go through the safety assessment process at ANVISA and the health technology assessment (HTA) done by the CONITEC, which includes an analysis of cost-efficiency. Only then is the drug available for free distribution in public hospitals and pharmacies.

[33] The CONITEC is a Commission of the Ministry of Health Care, created in 2011 to govern the incorporation of health technologies in the SUS through a process of Health Technology Assessment (HTA) similar to the one undertaken by the United Kingdom's National Institute for Health and Care Excellence (Sandra Gonçalves Gomes LIMA, Cláudia de BRITO and Carlos José Coelho de ANDRADE, 'Health technology assessment in Brazil–an international perspective' (2019) 24 Ciência & Saúde Coletiva 1709).

Figure 1: Organisation of the Brazilian Health System (SUS)



Source: The Commonwealth Fund[34]

Since its inception in 1990, the SUS has revolutionised the access to health care in Brazil, significantly expanding the primary care with a number of campaigns such as the Family Health Strategy, a community-based family health strategy which increased the access of basic health care from 54,69% in 1998 to 95% of municipalities in 2014[35]. However, as I

[34] Source: Roosa TIKKANEN, Robin OSBORN, Elias MOSSIALOS *and others*, *International Health Care System Profiles - Brazil* (2020)

[35] Rosália Garcia NEVES, Thaynã Ramos FLORES, Suele Manjourany Silva DURO *and others*, 'Tendência temporal da cobertura da Estratégia Saúde da Família no Brasil, regiões e Unidades da Federação, 2006-2016' (2018) 27 Epidemiologia e Serviços de Saúde e2017170

explore further in Chapter 2, Brazil is a country of deep inequalities, which spill over to the health care system. For instance, whilst Brasília has 30 ICU beds per 100,000 inhabitants, Rio de Janeiro 25, São Paulo 19, Paraná 18, Roraima has only 4 and Bahia 10 ICU beds/100,000 inhabitants[36]. The striking inequalities affect not only the enjoyment of the health care system by different populations and regions, but especially the *perception* of the quality of the system, which in turn has consequences for people's trust in the health care policy and the policy makers (discussed in Chapter 3).

The public, universal system, which is offered free of costs to any Brazilian, is also supplemented by a private health care system, which is optional and privately paid by consumers and workers (or their employers) directly to the health provider or through a insurance companies[37]. In 2020[38], 24% of Brazilians had private insurance. However, the private coverage is unequally distributed throughout the country. While in the southeast, 34,9% of citizens are privately insured, in the north only 14,7% of citizens have access to the private system[39].

This same inequality is also observed in the distribution of health care lawsuits throughout Brazil. As Octavio Motta Ferraz concludes, judicialisation of health is 'rather disproportionately concentrated in states and municipalities of the South and Southeast, which, together, account for approximately eight of every ten lawsuits in the country'[40]. This finding

[36] Available at National Register of Health Establishments 2019 (DataSUS)
(Alerrandre BARROS, 'IBGE divulga distribuição de UTIs, respiradores, médicos e enfermeiros' (*Agência IBGE Notícias*, 2020) <https://agenciadenoticias.ibge.gov.br/agencia-noticias/2012-agencia-de-noticias/noticias/27614-ibge-divulga-distribuicao-de-utis-respiradores-medicos-e-enfermeiros> accessed 21/10/2020)

[37] According to Silvia Gerschman, the private system was created to 'respond to a "market niche" where the public sector was deficient" (Silvia GERSCHMAN, 'Public and private health insurance in Brazil and European Union Countries' (2013) 1 Am J Public Health Res 78).

[38] Data from Agência Nacional de Saúde Suplementar (ANS), available at https://www.ans.gov.br/perfil-do-setor/dados-gerais (accessed on 11/06/2021)

[39] IBGE - Instituto Brasileiro de Geografia e ESTATÍSTICA, *Pesquisa Nacional de Saúde 2019*, 2020)

[40] FERRAZ, *Health as a Human Right: The Politics and Judicialisation of Health in Brazil*

is confirmed by the empirical analysis of health care litigation produced by Silva and Terrazas who show that over 60% of the claims analysed were from users of the private health system and represented by private lawyers (38,75%), patient's associations (21,25%) and public attorneys (30,63%)[41]. This finding find echo in the wider Brazilian literature conducting empirical analysis of health care litigation[42].

In the next section I provide an overview of the health care litigation phenomenon in Brazil and its consequences for the organisation of the public policy and budget.

1.2. Features and effects of mass health care litigation in Brazil

One distinctive feature of the health litigation which sets it apart from other countries[43] is the fact that the great majority[44] of lawsuits filed in Brazilian courts for access to health care is *individual*. That means that they are started by individuals, usually patients, either represented by public defenders or private attorneys, and result in particularised remedies only applicable to the parties involved in the lawsuit. These claims seek a *writ of mandamus* or specific condemnatory relief and are filed in the first-degree, usually requesting injunctive reliefs. Furthermore, because health care is a joint responsibility of all three levels of the state,

[41] Virgilio Afonso DA SILVA and Fernanda Vargas TERRAZAS, 'Claiming the right to health in Brazilian courts: The exclusion of the already excluded?' (2011) 36 Law & Social Inquiry 825

[42] For instance: Fabiola Sulpino VIEIRA and Paola ZUCCHI, 'Distorções causadas pelas ações judiciais à política de medicamentos no Brasil' (2007) 41 Revista de Saúde Pública 214; Januária Ramos PEREIRA, Rosana Isabel dos SANTOS, José Miguel do NASCIMENTO JUNIOR *and others*, 'Análise das demandas judiciais para o fornecimento de medicamentos pela Secretaria de Estado da Saúde de Santa Catarina nos anos de 2003 e 2004' (2010) 15 Ciência & Saúde Coletiva 3551, Fernanda de Freitas Castro GOMES, Mariângela Leal CHERCHIGLIA, Carlos Dalton MACHADO *and others*, 'Acesso aos procedimentos de média e alta complexidade no Sistema Único de Saúde: uma questão de judicialização' (2014) 30 Cadernos de saúde pública 31

[43] For instance, the United Kingdom, as analysed in Chapter 9, and South Africa (DUROJAYE, *Litigating the Right to Health in Africa*)

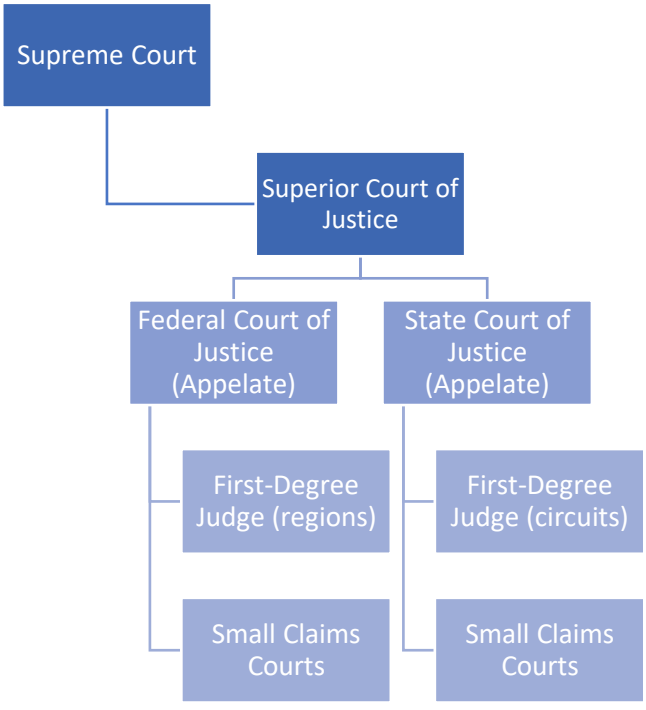
[44] Although there is significant variability on the number of collective claims in different regions, according to Insper, in 2018 only 2,35% of all health related claims in the appellate court were collective actions (DE AZEVEDO, ABUJAMRA and ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução*)

litigants can choose to start their legal action against the federal government (which would take them to federal courts) or against state and municipal governments (which would take them to state courts). Additionally, litigants can opt to start the claim in courts of justice (or ordinary jurisdiction) or small claims courts, depending on the value and complexity of their claim. This myriad of judicial options opened for individual litigants to start their legal action in Brazil results in a massification and atomisation of health care litigation throughout the country.

In order to clearly convey the complexity of the health care litigation phenomenon in Brazil, it is important to give a very brief overview of how the Judiciary in Brazil is structured.

Structure of the Brazilian Judiciary

Figure 2: Simplified Structure of the Brazilian Judiciary (Federal and State Courts)



The Brazilian judicial system is extensively regulated by the Brazilian Constitution of 1988. In a very brief explanation, it is structured on a five competences division: (i) federal jurisdictions, which is competent for adjudicating all litigations involving directly or indirectly

the Federal Union (in *personam*); (ii) state jurisdiction, with competence divided by each state of the federation, which is responsible for adjudicating all other litigations not governed by specialised jurisdictions; (iii) labour jurisdiction; (iv) electoral jurisdiction; and (v) military jurisdiction.

Besides the competence division, there is a hierarchical structure among trial judges, appellate courts, the superior courts and the Supreme Court. There are three basic levels of jurisdiction in Brazil: at the first level, a single judge controls the lawsuit from petition, trial, to judgment. The second stage is comprised of a state appeal court, one for each 27 states, or a regional appeal court, in the case of the federal justice. In the third and final stage is the Superior Court of Justice, which analyses the 'special appeals' - involving the interpretation of federal law, and the Supreme Court, which analyses the 'extraordinary appeals' - involving constitutional matters. All appeal courts, from appellate level to the Supreme Court, rule as a collegiate body. However, it has been empirically observed that judges and justices from collegiate bodies of all degrees extensively exercise individual power by deciding cases monocratically[45] - i.e., without taking them to the collegiate. In the context of the Supreme Court, for instance, that is interpreted as 11 judicial islands within one court[46]. The relevance of judicial individualism to the attenuated judicial activism in Brazil is discussed further in Chapter 4, where I address judge's interpretation of judicial independence concept.

As said above, at the apex of the Brazilian Judiciary is the Federal Supreme Court. The court is formed of 11 justices ('*ministros'*), 'who are appointed by the President of the Republic and must be approved by absolute majority in the Senate'[47]. The role of the Brazilian Supreme

[45] Diego Werneck ARGUELHES and Leandro Molhano RIBEIRO, 'Ministrocracia: o Supremo Tribunal individual e o processo democrático brasileiro' (2018) 37 Novos estudos CEBRAP 13

[46] Guilherme Forma KLAFKE and Bruna Romano PRETZEL, 'Processo decisório no Supremo Tribunal Federal: aprofundando o diagnóstico das onze ilhas' (2014) 1 Revista de estudos empíricos em direito

[47] Gilmar MENDES, 'Framework of the Brazilian Judiciary and Judicial Review', 2 <http://www.stf.jus.br/arquivo/cms/sobreStfCooperacaoInternacional/anexo/Framework_of_the_Brazilian_Judiciary__Inglaterra_Final.10.2009.pdf> accessed 13/9/2016

Court is to safeguard the Constitution. To do so, it combines powers of both decentralised, incidental form of judicial constitutional review, typical of the North American system, and abstract control of constitutionality, present in countries such as Germany and Italy[48].

In the concrete, or incidental review, the Supreme Court is mainly reached via the extraordinary appeals (referred to above). These appeals have features of the American *writ of error*, and since 2004, after the enactment of the Judiciary Reform Bill (constitutional amendment 45), the decisions rendered have binding effects throughout the country (*erga omnes*).

In this way, the Brazilian system of judicial review displays original and diverse procedural instruments for both controlling the constitutionality and protecting fundamental rights. But constitutionality can also be reviewed through concrete, diffuse control by a singular trial judge and by lower appellate courts. Hence, this further enables a more widespread increase in judicial power which also includes lower ranks of the court hierarchy in Brazil.

In the context of health care litigation, the widespread increase of judicial power and high success rates of lawsuits result in disruptive effects for the public budget and administration of the health care policy.

Effects of the health care litigation

The multiplication of judicial decisions granting access to health care via individual litigation is disruptive for the public budget and for the administration of the health care policy in Brazil. Furthermore, as the literature shows, it deepens the health inequality gap between

[48] Mauro CAPPELLETTI, *Judicial review in the contemporary world* (MICHIE 1971)

rich and poor[49], by enabling the access to expensive treatments and medical devices to those who are able to make use of the legal system (discussed further in Chapter 6).

For instance, as explained by one of the interviewees[50], due to the urgent nature of the cases, often granted through injunctive reliefs, the public administration is compelled to provide the drug or treatment immediately to the litigant. For that reason, the provision of the drug follows an 'urgent' procedure, which obliges the governments (local, state, or federal) to acquire the drug or offer the treatments for market price – hence, outside of the procurement procedures which allow governments to negotiate lower prices than those charged in the private market[51]. If the drug or treatment is not yet available in the Brazilian market, due to lack of registration with the Brazilian National Health Surveillance Agency, ANVISA, then the government is obliged to urgently import it, paying international market prices.[52]

Furthermore, the multiplication of successful health care lawsuits has not only significantly impacted the public budget, but also incentivised ethically questionable behaviours and fraudulent schemes by interested third parties (discussed in Chapter 7). For example, according to a public attorney from ANVISA, to avoid filing submissions to the Brazilian Health Regulatory Agency, ANVISA, several pharmaceutical companies finance individual litigation for patients who make use of their drugs[53] - either directly or through philanthropic associations. In other cases, private attorneys and medical doctors are responsible

[49] Which is assessed by the empirical literature by, for instance, identifying the number of litigants who come from the private health care system, and that make use of private legal representation (DA SILVA and TERRAZAS, 'Claiming the right to health in Brazilian courts: The exclusion of the already excluded?', VIEIRA and ZUCCHI, 'Distorções causadas pelas ações judiciais à política de medicamentos no Brasil')

[50] Interviewee 28 (2017) Interview with public attorney for the Secretary of Health in São Paulo (SP) [12/01/2017]

[51] The acquisition of drugs by the Brazilian public health care system is done in three stages: (i) definition of which drugs to include in the public system; (ii) definition of the quantity of drugs to be purchased and moment of purchase; (iii) price definition via public bidding, according to the procedures determined in the federal law #8666/93. These procedures are undertaken by the Health Ministry and the agencies, such as ANVISA.

[52] Interviewee 48 (2017) Interview with civil servant of Conitec in Brasília (DF) [06/02/2017]

[53] Interviewee 52 (2017) Interview with representative of pharmaceutical companies' association in São Paulo [09/02/2017]

for fraudulent schemes to force the State, via litigation, to acquire expensive medications and devices by filing claims for non-existing patients[54]. Even if these cases are a minority, its occurrence shows how the massification of successful lawsuits and atomisation in thousands of judicial districts around the country incentivise inefficient, unethical and potentially illegal uses of the judicial system.

Although the multiplication of successful individual claims seeking access to health care in Brazil have knowingly produced deep systemic problems – such as the ones mentioned above and other that will be described throughout this thesis – the responses offered by the Judiciary and Executive have mostly offered patchy solutions, which do not address the core systemic issues that I unpack throughout this thesis. My work does not intend to offer normative assessments or prescriptions. However, throughout the chapters I touch upon the few initiatives taken by different local and national institutions – such as the National Council of Justice and the regional prosecutor's offices – and the development of a recent case law from the Supreme Court which tries to impose some (although not sufficient) limits to the power of judicial intervention in health care cases.

Considering the dimension and complexity of the health care litigation phenomenon in Brazil, it does not come as a surprise that the legal community has been prolific[55] in writing about the theme in the last ten years[56], and continues to do so. For such reason this research

[54] For example, in 2015 the Brazilian Federal Police uncovered a mafia involving medical doctors, prosthesis manufactures and lawyers in Rio Grande do Sul, which used individual litigation to compel the state and private health insurance companies to pay for non-exiting or overpriced surgeries (Case number 001/2.16.0045415-0, 17ª Vara Criminal do Foro Central da Comarca de Porto Alegre, TJ/RS). In 2017, a similar scheme was discovered in Brasília (Case number 0707764-63.2019.8.07.0000, 3a. Turma Criminal, TJ/DF). As I will further explain in Chapter 1, according to interviewees there are numerous cases of frauds involving health care litigation.

[55] A quick search on *Google Scholar* using the terms 'judicialisation of health care Brazil', in Portuguese, (*judicialização da saúde Brasil*) results in over 19,500 academic publications (searched on 11th of November 2019).

[56] For instance, on how the extensive rights-bearing Brazilian Constitution enables judicial activism in health care, and the development of the judicial case law see Daniel Wei Liang WANG, 'Courts as Healthcare policy-Makers' (2013) 75 DIREITO GV Research Paper Series – Legal Studies and Francisco José Leal DE VASCONCELOS, Maria Socorro DE ARAÚJO DIAS, Maria José Galdino SARAIVA *and others*, 'Judicialização da Saúde: Análise de ações judiciais demandadas na comarca de Sobral, Ceará' (2017) 16 SANARE-Revista de Políticas Públicas

does not pretend to offer an all-encompassing review of the literature. Nonetheless, I draw attention to the body of literature which analyses the empirical consequences of health care litigation in Brazil, and in particular, the studies which develop an in-depth qualitative analysis of the phenomenon. For instance, looking at how the health care litigation in Brazil promotes inequality in the access of health care[57], the impact of massified litigation on the health care budget and policy procedures[58] and the role of pharmaceutical companies in incentivising health care litigation[59] - I review this literature further throughout the chapters. It is within the empirical, socio-legal literature about health care litigation in which my research is situated, and to which this thesis contributes. Moreover, as it will be further explained in Chapter 9, my work provides a middle-range theory about the interconnected socio-legal factors which help to explain the rise of successful health care litigation in Brazil.

This research starts from the hypothesis that behind each judge's decision to grant health care claims and litigants' decision to start legal action, there are important sociological factors which interact with, and often transcend, the interpretation and application of the formal law – i.e, in regard to the constitutional discourses about the universality of the right to health care and the limits of the state's capability of fulfilling such rights based on a constrained budget. I argue that it is essential to understand the underlying and interconnected socio-legal factors which influence the rise in numbers and successful outcomes of individual health care

Varun GAURI and Daniel M BRINKS, *Courting social justice: judicial enforcement of social and economic rights in the developing world* (Cambridge University Press 2008)

[57] For exemple, Octávio Luiz Motta FERRAZ, 'Harming the poor through social rights litigation: lessons from Brazil' (2010) 89 Tex L Rev 1643, Felipe Dutra ASENSI, *Indo além da judicialização: o Ministério Público e a saúde no Brasil* (FGV Direito Rio 2010), and DA SILVA and TERRAZAS, 'Claiming the right to health in Brazilian courts: The exclusion of the already excluded?'.

[58] For exemple, Julio Cesar MARCELLINO JUNIOR, 'O direito de acesso à justiça e a análise econômica da litigância: a maximização do acesso na busca pela efetividade' (2014) and Fabiola Sulpino VIEIRA and Paola ZUCCHI, 'Distortions to national drug policy caused by lawsuits in Brazil' (2007) 41 Revista de Saúde Pública 214

[59] For example,Ana Luiza CHIEFFI and Rita de Cássia Barradas BARATA, 'Legal suits: pharmaceutical industry strategies to introduce new drugs in the Brazilian public healthcare system' (2010) 44 Revista de Saúde Pública 421.

litigation in Brazil. Beyond the formal law, legal decisions and legal procedures, what features of Brazilian society, what social structures and institutional arrangements underpin the health care litigation phenomenon?

As I further explain in the methodology section 1.4, in order to answer the questions, I draw on semi-structured interviews with different actors involved in the health care litigation in Brazil. My goal with the interviews was to have a broad ranging, rich, contextual and in-depth understanding of how these actors perceive and describe health care litigation in the context of Brazilian society. My interview questions inquired into what my interviewees perceived as relevant factors underlying the increase of successful claims, and how the law featured as part of this. Furthermore, I aimed at unpacking the factors they described as underlying their decisions to take a particular action (i.e, start a legal action in the case of litigants, or grant/deny a claim in the case of judges).

These personal accounts revealed people's legal consciousness about, among other themes, the right to health care, access to justice, separation of powers, judicial activism, individualism and commodification of health, and the constitutionalisation of rights. They also disclosed, as I explore throughout chapters 3 to 7, wider social patterns, such as how Brazilians perceive and relate to the public sphere and how a widespread distrust in politics and public institutions in Brazil leads judges to disregard the public health care policy and the arguments of the public state's attorneys (during and outside of litigation), thus making them more prone to granting legal claims requesting drugs, treatments and medical devices not included in the Brazilian public health care policy. The interviews confirmed for instance, how the economic interest of powerful pharmaceutical companies[60], added to the interest of private attorneys and the patients' need to access health care, incentivise the development of a private and

[60] CHIEFFI and BARATA, 'Legal suits: pharmaceutical industry strategies to introduce new drugs in the Brazilian public healthcare system'

individualist litigation apparatus (which I call health litigation market) designed to access public resources through litigation. I analyse how all of these factors chime with a wider post-colonial social structure in Brazil, where resources are concentrated in the hands of a few actors, where public resources are poorly managed and used for private interest, and where citizens, suspicious of public authorities and feeling abandoned by the state, use any resources they can find to go about their lives - including starting legal action to request drugs or treatments they cannot access in public hospitals or public pharmacies.

My analysis of health care litigation in Brazil is thus based on three main pillars: (i) an account of the sociological background of Brazilian society; (ii) legal actors' (both lay and professional) understanding of the legal procedures, the constitutional and statutory law involved in health care litigation ('legal consciousness') and (iii) the development of contemporary inter-institutional relationships based on post-colonial social structures, such as individualism and patrimonialism. By dividing these factors into two subgroups I aim at showing how, within all pillars, there are components which are personal (internal) and others which are structural (external).

More specifically, internal factors refer to the personal features of the decision-making process (of either starting litigation in the case of litigants or granting claims in the case of judges) described by interviewees, such as emotions, beliefs and values – i.e., trust, self-empowerment, understanding of one's role in society, and a relationship with the public sphere are all examples of internal factors mentioned by interviewees. External factors refer to the elements which are exterior to the person, which (s)he cannot control but are perceived by him/her to have a bearing on her/his actions and perceptions. For example, the law, quality of government, corruption, costs of litigating, access to legal representation and separation of powers are such external factors.

Although I analytically divide between internal and external factors it is worth mentioning that this clear division between internal and external factors is a mere tool for analytical purposes. In reality, as the interviews show, these factors are inter-connected and influence one another. For example, the socially constructed perception that Brazilian politicians and public authorities are corrupt or inefficient is internalised and, when added to the personal experiences of the interviewee and to the wider social context of inequality, informs people's trust or lack thereof in the health care policy. These nuanced connections will be explained throughout chapter 3-7, when analysing each of the factors. Next, I briefly explain the methodology I chose to develop the study proposed in this thesis.

1.3 Methodology

To understand what are the main socio-legal factors influencing the rise of successful health care litigation in Brazil – including factors which inform a judge's decision to grant legal claims in health care litigation, and behind a litigant's decision to start legal action, I draw on a grounded theory approach, through an in-depth qualitative analysis of the original empirical data collected in Brazil from 2016 to 2017.

The data is comprised of 55 anonymised, semi-structured interviews with a wide range of actors involved in health care litigation, described in Table 1 below. The interviews focus on two main actors, judges and litigants. However, to get a wider, contextual understanding of the phenomenon, I also draw on interviews with other actors who interact with health care litigation, either directly or indirectly. That includes public defenders, private attorneys, civil servants from the health system, states' attorneys, as well as pharmaceutical company and patients' associations representatives.

Table 1: Key actors interviewed

Actors	Specifically	Number	Total
Judges	First Degree	8	19
	Appellate Court	4	
	Superior Court of Justice	3	
	Supreme Court	4	
Litigants	Won	9	12
	Lost	3	
Public Defenders	-	-	3
Prosecutors	-	-	4
Private Attorneys	-	-	3
State's Attorney	-	-	2
Civil Servants (Executive)	Ministry of Health Care	1	5
	CONITEC	1	
	Secretary of Health Care	1	
	ANVISA	2	
Medical Doctors	-	-	2
Representatives of Pharma. Companies	-	-	2
Patients' Associations	-	-	3
Total			55

As I explore further in the empirical chapters (3 to 8), the decision to interview a wider range of health litigation actors was taken, initially, to explore how different actors understood and described the phenomenon, and what roles they played in health care litigation in Brazil. This methodology ultimately enable me to have a fairly comprehensive and nuanced view of the phenomenon. Furthermore, the findings highlighted striking similarities in the socio-legal factors described by the different actors despite their different roles – i.e., a deep-seated distrust in the health care system (and the executive, more generally), the willingness of judges to grant

claims based on a broad interpretation of the Constitution, and the economic interest of actors – such as pharmaceutical companies - which incentivise, through financial support, litigant's individualism seeking to access drugs and treatments not offered in the public health care system.

The selection of interviewees followed a snowball sampling method, which was useful to identify relevant interviewees and to get access to them by using referrals. According to Atkinson, snowball sampling is useful when the population is hard to access (i.e., elite interviewees) and requires a degree of trust to gain access[61]. Due to the limitation of time and resources, and the large size of Brazil, I focused my interviews in 5 states – São Paulo, Rio de Janeiro, Santa Catarina, Paraná and Brasília. The choice of geographical region was a combination of relevance (i.e., States with a high incidence of health care litigation) and convenience (which included access to the participant).

Judges were identified through two main methods: an initial research of jurisprudence on the online system of the state and federal courts using the terms "health care", "access", "sus" and "196", and referral from other judges or legal professionals, such as public defenders, private lawyers and public prosecutors. Litigants were identified also through case law research, Facebook groups (i.e., groups of mothers seeking access to special milks such as neocate and groups of rare disease patients such as ALS), and through private attorneys, public defenders, and patient's associations' reference. This snowballing technique of being referred to new interviewees by a previous interviewee also opened-up access to civil servants from the health care authorities, medical doctors, public defenders and private lawyers (i.e., law-firms specialised in health law, or who represented interviewed litigants) who referenced one-another. Finally, I also contacted judges and other legal actors who had participated in the

[61] Rowland ATKINSON and John FLINT, 'Accessing hidden and hard-to-reach populations: Snowball research strategies' (2001) 33 Social research update 1

Jornadas da Saúde (Health Forum) organised by the National Council of Justice at date. The snowball sampling technique thus allowed me to interview relevant actors that formed part of the network of legal actors experienced in health care litigation.

The selection of interviewees was done with the aim of accessing a wide range of perspectives *relevant*[62] to the health care litigation phenomenon, including judges from all levels of jurisdiction, from both capital and smaller cities, with some of them having no specialisation while others having a deeper academic understanding of the discussions of health care litigation (including through participation of health fora such as the *Forum da Saúde* organised by the National Council of Justice or other local discussions promoted by governments and the judicial system). From the litigant's side, I aimed at encompassing the perspectives of litigants who used private lawyers and public defenders, who had help of patient's associations, who litigated high-cost drugs and lower cost drugs, from different income levels (i.e., who lived in poorest areas (i.e., favelas) and middle-class regions of capitals, who used the private and public health care system), who lost and won. To those perspectives of the health care litigation, I then added the impressions of the other actors, such as public prosecutors, public defenders, private lawyers, representatives of patient's associations and pharmaceutical companies, civil servants of the health system, and medical doctors from both private and public system who shared nuanced perspectives of the phenomenon, and of litigant's and judge's behaviour.

The choice of an in-depth, qualitative data-based research design comprised of long, semi-structured interviews (of 45 to 90 minutes per interview), is one which does not intend to give a generalised and generalisable explanation of a phenomenon, but rather seeks to analytically capture and explain the nuances of an increase in successful health care litigation

[62] Alan BRYMAN, *Social research methods* (Oxford university press 2016)

claims in Brazil. This extends to an account of the contextual canvas[63] of post-colonialism and deep inequalities. Therefore, my research does not intend to provide for quantitative analysis of very large data sets, and it does not intend to offer results that are generalisable to all of the population, i.e. the entirety of health care litigation claims in Brazil. However, my findings contribute to a deeper, more nuanced understanding of a set of interrelated socio-legal factors that drive successful health care litigation in Brazil.

The interviews followed a semi-structured questionnaire approved by Oxford University's Curec I Ethics Committee (Annex 1). The questionnaire was designed to give an initial opportunity for the interviewee to describe the phenomenon in his/her own words, either by asking what were the explanatory factors (s)he attributed to the rise of successful health care claims (in the case of legal professionals and 'elite' interviewees), or by asking them to describe their health case and the process of acquiring the drugs through litigation (in the case of litigants) and what had influenced the litigant to start litigation. I would then follow up on themes and factors expressed by the interviewees themselves and ask them to describe these further. An analysis of these nuanced responses is provided throughout the empirical chapters (3-8). Therefore, the questionnaire in Annex 1 should be used as a reference, but one must bear in mind that for each interviewee the questions followed different orders, and included themes not necessarily discussed with all interviewees.

Once transcribed, I analysed the interviews thematically. With the use of NVivo I coded the interviews by grouping them into key concepts, based on patters within the data – for example, trust, emotions, judicial activism, judicial empowerment, legal consciousness (mentions to rights, the Constitution, and specific legal provisions), understanding of judge's role in society, quality of government, corruption, third parties' interest and cost of litigation. These concepts form the basis of the analysis presented in the empirical chapters 3 to 7. Each

[63] John M JOHNSON, 'In-depth interviewing' (2002) 1 Handbook of interview research: Context and method

chapter addresses the key themes empirically identified which are analysed in light of the relevant legal and sociological literature, and the sociological context explained in chapter 2. Therefore, the critical literature reviewed is undertaken in each chapter, throughout the thesis.

The result of this examination forms the basis for the middle-range theory[64] about the inter-connection of internal and external factors in the health care litigation phenomenon as discussed further in Chapters 3 to 7.

[64] "Middle-range theory involves abstractions, of course, but they are close enough to observed data to be incorporated in propositions that permit empirical testing. Middle-range theories deal with delimited aspects of social phenomena, as is indicated by their labels" (Robert King MERTON, *Social Theory and Social Structure* (The Free Press 1968))

CHAPTER 2 - LEGACIES OF COLONIALISM: HOW PATRIMONIALISM, CONCENTRATION OF POWER AND THE LAW SHAPED BRAZILIAN SOCIETY AND CONTRIBUTED TO THE RISE OF HEALTH CARE LITIGATION

In this chapter I present a critical analysis of the sociological literature about the historical development of the Brazilian society and its institutions, mostly drawing from the work of prominent Brazilian anthropologist Roberto da Matta, and sociologists Sergio Buarque de Holanda and Raimundo Faoro. The discussion I develop in this Chapter will allow me to place and explain the findings of my empirical research about health care litigation in a wider context of Brazilian culture[65] and identity construction[66]. To do so I propose to answer the following two main questions. The first, overarching question is: how can the internal and external factors described by litigants and judges, such as distrust and individualism, be connected to the colonial history of Brazil and to the social structures of the country? Second, how do characteristics of the Brazilian society, such as the power-structure of patrimonialism/patronage, clientelism and individualism influence the agency of citizens, who may consider the start of legal action to access health care, and public officials, such as judges, who may decide on granting access to health care not included in the public policy?

[65] By using the term culture, I am referring to the body of objects of a society. That includes the share beliefs, values, rules, tools, technologies, and institutions of a society. The importance of the concept of culture, as David Hess describes, is its power to 'cut across a wide variety of domains of a society' from arts, rituals to the economic and political institutions, enabling to identify common traits in various areas of Brazilian culture which are tied to by the *brazilianess*. (David J HESS, Roberto DA MATTA and Roberto DAMATTA, *The Brazilian puzzle: culture on the borderlands of the western world* (Columbia University Press 1995) 26)

[66] '[I]dentity is actually something formed through unconscious processes over time, rather than being innate in consciousness at birth. There is always something "imaginary" or fantasized about its unity. It always remains in-complete, is always "in process", always "being formed".' (Stuart HALL, David HELD and Tony MCGREW, 'The question of cultural identity, modernity and its futures' (1992) Modernity and its future 68)

I would like to state a caveat to begin with. The goal of this chapter is not to defend or criticise particular academic positions on the interpretation of the Brazilian society, or to explore in depth the anthropological nature of modern Brazil. The aim here is to provide a background which will then serve as a contextual basis for the analysis of the empirical data about health care litigation. Therefore, contrasting views present in the literature will be noted when relevant, but are not the focus of attention here.

2.1 Portuguese colonization and the construction of an identity for Brazilians

The Brazilian society we know today resulted from the syncretism of the Portuguese colonisers, the native silvicultural indigenous peoples, the enslaved Africans and European immigrants. The unity of identities observable in the contemporary Brazilian society[67], resultant from the mix of these diverse people, is quite unique and does not see parallels in the Spanish colonies. It was not, however, without a cost. As the prominent Brazilian anthropologist Darcy Ribeiro explains, the identity unity observed in Brazil was in fact a consequence of a continuous and violent processes of political unification, which suppressed any discrepant ethnic identities or separatist tendencies[68]. According to Ribeiro, the national identity of Brazilians was shaped by the cultural references brought from Europe by immigrants mixed with the creativity of the local people. Caio Prado Júnior suggests that this mixture produced a society full of controversies and limitations, which had its foundations set by a clear juxtaposition between the slaves and the agricultural high class (the *gentis*). [69]

[67] As it will be discussed further in this chapter, there is much controversy about this notion of unity amongst Brazilian people. Part of the literature suggests that this syncretism is a tale imposed by the colonisers to hide a practice of violence and subjugation of black and indigenous people.

[68] Darcy RIBEIRO, *O povo brasileiro: a formação e o sentido do Brasil* (Global Editora e Distribuidora Ltda 2015) 16

[69] Caio Prado JÚNIOR, *Formação do Brasil contemporâneo*, vol 1 (Editôra Brasiliense 1945)

Portugal's main reason for colonizing Brazil was exploratory. Given the dimensions of the country, and the consequent difficulty of controlling it, to make sure the exploration of the colony was viable and effective, the Portuguese acted through *coronéis*[70] (barons) who received land and slaves as gifts from the Portuguese Crown[71] with the duty of protecting the land and managing the local people. This legal scheme, called hereditary captaincies (*capitanias hereditárias*), was the way through which Portugal could control the country and guarantee its exploitation. By dividing the land and entrusting each fraction to local lords (*coronéis)* who looked after the Portuguese interests, the Metropolis guaranteed its profit and, as payments, the *coronéis* kept their part of the profit and the power to control their part of the land independently. The transmission of land ownership was therefore not passed on to descendants of the Portuguese (hereditary) but entrusted to the local *coronéis* who served a public function.

As Darcy Ribeiro explains, the formation of the Brazilian society - as well as the rest of the Americas - was a result not 'of the conjunction between autonomous entities' but a 'process of expansion of empires through civilising activity and the subjugation of populations'[72]. The result of this imperialism was the transfiguration and acculturation of peoples of the colony by the *ruling peoples* of Europe, who exploited the *dominated peoples* and the lands of the New World.

[70] 'Unlike the common view that Brazilian colonisation was based on the many adventurous single males who left Portugal in search of their fortune in the new world (vis-à-vis the 'family character' of North American colonisation), the driving economic and political force rested on the wealth and power of traditional families' Márcio M VALENÇA, 'Patron-client relations and politics in Brazil' (1999) Research Papers in Environmental and Spatial Analysis 4

[71] In *The Brazilian Puzzle,* David Hess compares the Brazilian plantation hierarchical legacy to a 'radically different' model present in the colonies of the United States and Canada. According to the author, the society in those places was more egalitarian and based on a small-scale bourgeois capitalism of family farms and urban merchants, under a less centralised state. The lack of checks on the power of the large landowners in Brazil is compared by Hess to a 'medieval feudalism' (HESS, DA MATTA and DAMATTA, *The Brazilian puzzle: culture on the borderlands of the western world*).

[72] Darcy RIBEIRO, *O processo civilizatório: etapas da evolução sociocultural*, vol 1 (Companhia das Letras 1998) 38

The subjugation and exploitation of the colony bore important consequences for how the national identity developed in Brazil. For instance, it affects how Brazilians relate to the public sphere as privately owned spaces. This, in turns, fostered a deeply rooted distrust between citizens and its public institutions. In other words, the fact that the landowners in Brazil received their lands as donations from the Portuguese Crown in order to protect the private interests of the metropolis, and that these *coronéis* acted as owners of the land and its people, had ramifications for the modern Brazilian society, or at least, for how Brazilians perceive their relationship with public power, i.e., as one of domination and unjustified privilege.

In the context of health care litigation, for example, the *use* of judicialisation of health care can be also understood as way of working the system to achieve personal advantages – i.e., access to a drug which is not available to the wider population at the expenses of the public budget. In other words, the way individual litigants use and understand their right to start legal action to get access to a drug or treatment not provided by SUS (discussed in Chapter 6), and similarly, how pharmaceutical companies use the litigation system to advance their interests (explored further in Chapter 7). For instance, one litigant reflects about how health care litigation is an unavoidable consequence of corruption and lack of interest from those in power:

> I think that unfortunately in the country where we live, the ones who are up there, responsible for providing support for us down here, they unfortunately don't think about the people. They only think about themselves. Unfortunately, we live in a country of great corruption. I think that there is very little money left for public health care. So, people need to go to the Judiciary because they cannot get access to health care vis SUS. [Litigation] is not the reason why the SUS does not provide the basics. I don't think it is because the system spends X amount on high-cost drugs ... I don't believe that. For me this an excuse, unfortunately. I do not think that this money would return to us in any other way. I think that if there was not so much corruption, the amount of taxes that we pay would be enough [to provide citizens with health care][73].

[73] Interviewee 47 (2017) Interview with litigant from Campinas (SP) [03/02/2017].

In “Owners of Power”[74], sociologist Raymundo Faoro, drawing from Max Weber’s lessons, classifies the above-mentioned colonial roots of the Brazilian state as a *patrimonial*. According to the author, in a patrimonial state, the public and private worlds and their assets are not well defined or dissociated. To those in power, there is a mix-up in the perception of what is public and what is private. Furthermore, the relationships between individuals as well as the ones between government and its citizens is based on a *patronage-client* foundation. ‘The captaincy system was Portugal’s attempt to occupy and colonise the newly discovered land at little or no cost to the royal treasury’.[75]

Following the classic work of Faoro and Holanda, scholars accepted and internalised this social-anthropological explanation of the troubled relationships Brazilians have with economic and/or political power, hierarchy, and the public sphere. As exemplified by the interview quote above, and as it will be shown throughout the empirical chapters of this thesis, this generalised perception of a corrupt, privatised public sphere in Brazil, can be observed throughout the interviews with all categories of interviewees – litigants, judges, public officials, lawyers, medical doctors, representatives of the civil society and pharmaceutical companies. Hence, based on the critical analysis of the literature undertaken in this chapter, and the empirical findings emerging from the data collected in Brazil, I suggest that the patrimonial/patronage framework can be broadly taken as a means of explaining the nature of the Brazilian state and societal power relationships, which, in turn, provides a foil against which decisions with regard to health care litigation are taken.

Contemporary scholars from sociology, anthropology, political science and law, connect the patrimonial heritage of Brazil’s colonial period to the dynamics observed in the current political and economic elite, such as nepotism, privileges, and corruption. The

[74] Raymundo FAORO, *Os donos do poder-formação do patronato político brasileiro* (Globo Livros 2013)

[75] VALENÇA, 'Patron-client relations and politics in Brazil'

contemporary clientelism and patronage is referred to in the literature as *neopatrimonialism* or bureaucratic patrimonialism[76]. However, Anthony Pereira alerts to the insufficiency of using neopatrimonialism to fully explain the relationships of power and modern institutions in Brazil. The author stresses the importance of not generalising and oversimplifying a complex country such as Brazil[77]. It is undeniable, nevertheless, that this construction of a neo-patrimonial society in Brazil, based on privileges and hierarchy has spread throughout the social-science scholarship[78] and permeated the national-identity construction[79]. Even if we disagree with the idea that contemporary Brazil is a neo-patrimonial State, as Anthony Pereira suggests, the fact is a large segment of the population, including those in power, *perceive* Brazil as such[80]. And most often than not people act based on their perceptions[81] and social constructions.

As it is mentioned above and will be explored throughout chapters 3 to 7, it is quite clear how the perception that Brazil is ruled by a patrimonial elite is present in the contemporary imaginary of Brazilians. This notion that Brazil is a country with poor

[76] José Maurício DOMINGUES, 'Modernity, Tradition and Reflexivity in Contemporary Brazil', *Social Creativity, Collective Subjectivity and Contemporary Modernity* (Springer 2000); Rafael Pacheco MOURÃO, 'Celso Furtado e a questão do patrimonialismo no Brasil' (2015) 24 Teoria & Pesquisa: Revista de Ciência Política ; Karsten BECHLE, 'Neopatrimonialism in Latin America: Prospects and promises of a neglected concept' (2010) ; Simon SCHWARTZMAN, 'Bases do autoritarismo brasileiro' (1982) ;

[77] Anthony W PEREIRA, 'Is the Brazilian State "Patrimonial"?' (2016) 43 Latin American Perspectives 135

[78] For discussions on the theme of patrimonialism and bureaucracy in Brazil: Derick W BRINKERHOFF and Arthur A GOLDSMITH, 'Good governance, clientelism, and patrimonialism: New perspectives on old problems' (2004) 7 International Public Management Journal 163; José Antonio Gomes de PINHO and Ana Rita Silva SACRAMENTO, 'Brazil: between the modern bureaucracy of Weber and resilient patrimonialism' (2015) 13 Management Research: The Journal of the Iberoamerican Academy of Management 140; Simon SCHWARTZMAN, 'Regional Contrasts within a Continental-Scale State: Brazil' (1973) Building States and Nations: Analyses by Region Beverly Hills: Sage Publications 209; Frances HAGOPIAN, *Traditional politics and regime change in Brazil* (Cambridge University Press 2007)

[79] For different empirical accounts on people's perception of corruption and quality of government in Brazil: Lourenço Stelio REGA, 'Dando um jeito no jeitinho' (2000) São Paulo: Editora Mundo Cristão ; Cristina NOVAES, Sarah LASSO and Emerson Wagner MAINARDES, 'Percepções de qualidade do serviço público' (2015) 9 Revista Pensamento Contemporâneo em Administração 107; Valéria Cabreira CABRERA, 'Cultura Política e Adesão à Democracia: uma análise a partir da percepção do cidadão brasileiro sobre direitos humanos', Universidade Federal de Pelotas 2016)

[80] PEREIRA, 'Is the Brazilian State "Patrimonial"?'

[81] On the concept and application of the relationship of perceptions, beliefs and facts: Andy EGAN, 'Seeing and believing: Perception, belief formation and the divided mind' (2008) 140 Philosophical Studies 47

governance, ruled by a corrupt and inept political elite who owns power instead of using it as a tool for the development of society was in a way present throughout most interviews I conducted.

> [Corruption] is not new, this comes from the times Brazil was an empire. We come from a culture of corruption. It is the same as eating rice and beans[82].

I do not, in any way, want to convey the image that Brazilian society has not *evolved* since colonisation. As Roberto DaMatta defends, the notion that Latin America is a 'sociological disaster' comes from the logic of observers who do not question their own starting point.[83] There are many nuances to the Brazilian history and the development of its society and public institutions. Moreover, judging the quality of this development is not the object of this thesis. The purpose of this sociological background chapter is to show how the relationships established in the context of the Brazilian colony are still reflected in the contemporary *perception* of power relations and the social *imaginary*, which in turn has a bearing on the phenomenon of health care litigation.

An important aspect of the patrimonial state is the relationship developed between those in power, the offices they hold and the exercise of authority. In the same way that private interests mix with those of the public sphere in the patrimonial state, the persons in power also get mixed-up with the office they hold. This *personalism* is essential to understand how Brazilians relate to power and it influences their decision-making processes. In Chapter 4 I explore empirical instances of this *personalism* through the analysis of judges' self-empowerment and professional identity construction.

[82] Interviewee 12 (2016) Interview with litigant in São Paulo (SP) [24/11/2016]

[83] Roberto DAMATTA, 'For an anthropology of the Brazilian tradition; or 'A virtude está no meio'' (1995) The Brazilian puzzle: Culture on the borderlands of the Western world 270 (pg. 270)

2.2 Personalism and the Cordial Men: Do You Know Who You Are Talking To?

In a lecture given at Harvard University in 2017, the justice of the Brazilian Supreme Court, Luís Roberto Barroso, discussed nepotism as a clear example of the patrimonialism present in the Brazilian state until the current days. According to him, the confusion between private and public interests is so deeply carved in the Brazilian culture that the 1988 Constitution had to expressly veto appointing relatives or friends for public offices. The Justice recalls that when the Supreme Court ruled on the case that came to prohibit nepotism in the Judiciary[84], a judge from an appellate court declared to the press: 'If I do not take care of my own, who will?'[85].

In this environment of patrimonialism, Brazilians developed rituals of exercising and dealing with authority. These rituals mark not only important features of the dynamics between Brazilians but are also an essential part of the national identity. Two of these rituals, the *jeitinho* and the phrase '*do you know who you are talking to*?', which I further explain in section 2.3 below, represent opposite, dialectical characteristics of this dynamic[86]. Both need to be understood for a deeper sociological analysis of the factors influencing health care litigation in Brazil. I will start by discussing the notion of 'do you know who you are talking to?'.

> Consider one example (…): someone has parked a car illegally and is stopped by a police officer, who asks the person to move to the car […] a well-connected Brazilian might ask the police officer: 'Do you know who you're talking to? I'm a friend of so-and-so, who is a friend of so-and-so, who is your boss.'(...) the outcome of such a situation might be that the traffic offender would walk away angrily, and a few days later the police officer might actually be obliged to apologise. In other words, the parking offender occupies a social position above that of the police officer and has the personal connections to interfere in the police force.[87]

[84] ADC 12/DF, Carlos A. Britto, (2008) (Brazilian Supreme Court).

[85] The lecture can be found at http://www.migalhas.com.br/arquivos/2017/4/art20170410-01.pdf##LS

[86] Roberto DA MATTA, *Carnivals, rogues, and heroes: An interpretation of the Brazilian dilemma* (University of Notre Dame Press 1991)

[87] HESS, DA MATTA and DAMATTA, *The Brazilian puzzle: culture on the borderlands of the western world*

The quote transcribed above is an example of the 'do you know who you are talking to?' dynamic given by Da Matta. It describes a ritual, a social drama, which transforms a formally egalitarian society - where all are subject to the same laws - to one of hierarchy and personalism. Implicitly, there are two legal systems; one applied to a very small economic and political elite, and another to the rest of society.

Interestingly, the use of personal connection for private gain is not limited to the high ranks of authority in Brazil. The same strategy can be identified in the everyday relationships of Brazilians of all social-economic classes. For example, a litigant who sued the state of São Paulo talks about how her/his personal connections enabled her/him to get easier access to a drug not included in the public policy:

> In Brazil you cannot have access to anything unless you have a personal contact. For example, the father of my friend was sick. My husband knows everyone here in São Gonçalo, from the beggar to the politician. He got in touch with the administrator of the secretary of health care, who is his friend, and got a placement for her father. The other people who were waiting for a place for much longer, did not get it. Those who have contacts get everything.[88]

DaMatta explains that albeit a common practice, the use of the 'do you know who you are talking to' is something that Brazilians are ashamed of. According to the sociologist, Brazilians are a people famous for the Carnival, for its warmth, informality and friendliness who like to be known for their cordiality. The "do you know who you are talking to?" is the negation of this cordiality[89] insofar as it substitutes the friendliness and *equality* of the Carnival for an imposing and officious hierarchy, where some seem better and more powerful than others. It remains in the realm of social practices that do not reach the formal law but can in turn subvert the application of the rule of law.

[88] Interview with litigant from Rio de Janeiro on December 12th, 2016.

[89] DA MATTA, *Carnivals, rogues, and heroes: An interpretation of the Brazilian dilemma*

As another interviewee points out, Brazil is a developing country where the rule of law is not applied equally to all, where corruption takes resources from society and enriches a few powerful members of society[90]. All of it hiding beneath a constitutional discourse of equality[91]. Another extract from the interviews conducted in Brazil provides a link between health care litigation and this Brazil of double standards captured by DaMatta's 'do you know who you are talking to': An interviewee from São Paulo, who got access to her/his sclerosis medication through litigation describes the procedure of collecting the drug[92]. (S)he describes that in the pharmacies specialised in high-cost drugs, there is a queue for patients to pick-up the medications covered by the public health care system, and, to the right, there is a side-door designated specifically to deliver drugs granted by judges via health care litigation, and thus not available on the other 'common' counter. In this scenario, the judicial decision gives to its bearer a power to cut the queue, to be treated differently from the other users of the public health care system, SUS.

In the same way that the *personalism* is an essential aspect of how Brazilians deal with power relationships, *individualism* is another characteristic of the Brazilian society that must be explored in order to unpack the sociological environment in which health care litigation takes place.

2.2.1 Family and the Cordial Men

In the Weberian typology of power, the patrimonial domination follows from a traditional form of hierarchy, centred around family structures – also known as the patriarchy.

[90] Timothy J POWER and Matthew M TAYLOR, 'Corruption and democracy in Brazil' (2011) South Bend, IN and Claudio FERRAZ, Frederico FINAN and Diana B MOREIRA, 'Corrupting learning: Evidence from missing federal education funds in Brazil' (2012) 96 Journal of Public Economics 712

[91] Interviewee 35 (2017) Interview with representative of a patients' association in São Paulo (SP) [17/01/2017]

[92] Interview with litigant conducted on December 12th, 2016, in Campinas, state of São Paulo.

During the colonial times in Brazil, each *senhor de engenho* - landowners of sugar-cane plantations - exercised absolute authority over their lands, bearing the uncontested authority of a *pater familias*. In return for the land conferred to the captain-holders, Portugal demanded their loyalty and support. The inter-personal relationships were a source of power and prestige. And, by exchanging favours and granting privileges to those closely related, the powerful maintain their personal power and family success.

Personalism is a cultural system that 'gives people a social address in a hierarchical society'[93]. It is also a means to achieving personal gain. In colonial Brazil, it was essential to develop close personal relationships of an affective nature, which were coined by Ribeiro Couto, but made famous by the anthropologist Sérgio Buarque de Holanda, as the 'cordial men'.[94]

The notion of the 'cordial men' is essential to understand the constant tension identifiable in the Brazilian society.[95] According to Holanda, this cordiality, so typical of Brazilians, cannot be mistaken for good manners and has, in fact, a deep *emotional* base.[96] In a place where personal relationships are essential for success, being friendly and close to those in power is the way to govern self-interests. Hence, for the 'cordial men' the individual interest is above the common interest. To Holanda, this dynamic is the proof that the interests of the family are above those of the society, and that public relationships are based in relational dynamics.[97]

[93] HESS, DA MATTA and DAMATTA, *The Brazilian puzzle: culture on the borderlands of the western world*

[94] Sergio Buarque DE HOLANDA, *Roots of Brazil* (University of Notre Dame Pess 2012)

[95] Is worth mentioning that Roberto DaMatta disagrees with the idea of incoherencies. For him, what for some is perceived as a contradiction, is what he calls a dilemma - a dialectic relationship between different, complementary, ethics. (DAMATTA, 'For an anthropology of the Brazilian tradition; or 'A virtude está no meio'')

[96] DE HOLANDA, *Roots of Brazil*

[97] Ibid

In personalistic societies, social interactions follow a relational dynamic. Individuals are not driven by egalitarian rules of the game, which apply universally to all. They are tied to personal loyalties and power heritage. There is no sense of community, and the civic individualism is replaced by a transgressive personalistic individualism which relies on fixes, favours, stop-gaps and other privileges granted to the 'friends of the friends'. This sheds light on several questions raised throughout this research, particularly on the constant tension between a claimed individual right to health care and a public policy designed to suit the collective interest. One of the consequences of a patrimonial society is the difficulty of creating a sentiment and agency of community (collectivism), therefore weakening all forms of organisations and associations. 'In a land where all are barons, lasting group agreement is not possible'.[98]

Individualism as a sociological factor behind the increase of successful health care litigation is further explored in Chapter 6 and 7, where I analyse why litigants decide to start individual legal action and how the private interest of a third party, such as the pharmaceutical industry incentivises such decisions.

Furthermore, as mentioned above, *emotions* are another essential element of this 'cordial' society. State affairs are mixed with private ones, and the rationality of legal bureaucracy is blurred by emotional discourses and relational decision making. This is another important theme present in the interviews that I conducted with public officials and judges in Brazil. Emotions, particularly the sentiment of empathy towards the suffering of the litigant, was a factor brought up by almost all judges swaying them to grant health care claims (further discussed in Chapter 4). According to a Supreme Court Justice[99], the relevance of emotions when judging health care cases was one of the reasons why the upper courts should take the

[98] Ibid

[99] Interviewee 3 (2016) Interview with a Supreme Court judge in Brasília (DF) [17/11/2016].

issue into their own hands. In his/her opinion, the higher position of Justices permits a detachment from the case that the judge in lower courts cannot achieve. Thus, his/her position was that it was the Supreme Court's responsibility to alleviate the pressure on lower court judges having to deal with emotional decisions such as those involved in individual access to health care litigation, often involving citizens of their own local communities.

Another characteristic of the *cordial men* is the use of a contradictory discourse aimed at disguising the true nature of intentions and behaviours. According to the literature, this incongruity is closely related to the colonial subjugation of the Brazilian society and the imposition of an alien culture[100], perceived as more mature and evolved.

The contradictions between the formal and informal, otherwise known as the 'law in the books' and the 'law in action' abound in Brazil. While, on the one hand, Brazil's legal system is extremely formal and complex, mimicking an ideal of order that Brazilians wish to achieve, on the other hand, there is the Brazil of Carnival, of mixed-races and the *do you know who you are talking to* which operates in the shadows, or in spite of the law[101]. Both the formal and the informal are real, present and operating in Brazil. To Da Matta, there is a dialectic contraposition which happens between the formal level and the unwritten personal codes of conduct.[102]

This duality is very much observable in the contemporary Brazilian health care litigation phenomenon. The Judiciary, for instance, reinforces time and time again the importance of its role as an independent adjudicator; one bound to the law, the constitutional

[100] 'In its expansion, the European formulas of truth, justice and beauty are progressively imposed as compulsory values. So powerful by the persuasive force of their universality, as by the coercive mechanisms through which they spread.' RIBEIRO, *O povo brasileiro: a formação e o sentido do Brasil*

[101] Some case-studies, however, demonstrate that in exceptional circumstances regulators in Brazil have shown to be capable of finding ways around the conventional practice of bureaucracy and excessive regulation, in order to ways to develop compliance while still following legal standards. Two interesting examples can be found at: Salo COSLOVSKY, Roberto PIRES and Susan S SILBEY, '23 The pragmatic politics of regulatory enforcement' (2011) Handbook on the Politics of Regulation 322.

[102] DAMATTA, 'For an anthropology of the Brazilian tradition; or 'A virtude está no meio''.

principles and to the facts of the case; free from political pressures and, in all possibilities, impartial to personal political positions. This narrative, as I will explore in more detail in Chapter 5, is grounded in legal text.

Nevertheless, the interviews revealed the strong political convictions of judges, who describe his/her personal responsibility to act in order to protect the vulnerable, oppressed citizen from the patrimonial political elite who rules the country for its own gains through corruption and bad *bureaucracy*. However, in the formal, written judgements, the reasons given for the outcome of the claim are not political, they are technical, grounded on the formal law. They operate within the reality of *de jure*, of a legal language created not by the average Brazilian citizen or for the average Brazilian citizen.[103]

By saying that during interviews judges gave justifications that differed from the formal law and those found it their public written decisions, I do not in any way try to convey the idea that Brazilian judges are deceiving the public or that they have bad intentions when deciding. On the contrary, during their interviews most judges displayed an active will to 'do good' and enforce the promises of the constitutional wording. However, the contradiction between the reasons for the successful outcome in a legal case presented during the interviews, which were essentially political and personal in nature, against the formal legal rationale offered in the case law, can be read under the light of the tension between the formal and the social praxis, which has been present in the Brazilian society ever since colonisation.[104] This is why, as Roberto DaMatta puts it, Brazil is a puzzle. Because it does not conform to any one Weberian ideal type of state: either authoritarian or bureaucratic. It has features of both. It is a constitutional democracy with rigid laws and a complex judicial system, as well as a country of hierarchy, domination and corruption.

[103] Roberto KANT DE LIMA, 'Bureaucratic rationality in Brazil and in the United States: criminal justice systems in comparative perspective' (1995) The Brazilian puzzle: Culture on the borderlands of the Western world 241)

[104] DE HOLANDA, *Roots of Brazil*

As Alexandre Zaidan points out, in order to understand the complexity of the Brazilian Judiciary it is important to observe it through two prisms: one that considers the semantics of its self-description as an autonomous power that legitimates itself in defence of fundamental rights and the break with the authoritarian past, and the second which takes into account the elements of the structure of the interests mobilised in its operation and the series of limitations they impose on the autonomous affirmation of the law in the context of inequalities and social exclusion in the country.[105]

The way judges adapt the interpretation of the law to the political necessities present in the concrete case can be interpreted as an expression of the flexible quality of Brazilians and Brazilian culture. Adapting to the social reality, unequal and often unfair, requires a creativity typical of what Da Matta called the *jeitinho*.

2.3. *Jeitinho* and the law: a dialectic relationship between the formal law and the law in action

In a land where community is not strong and the political and economic powers are concentrated in the hands of a patriarchal and patrimonial state, people either get crushed by the system, rebel against it or find ways to work around it. The way Brazilians found, is what has become famously known as the 'jeitinho brasileiro' (literally, the Brazilian way).[106]

According to Keith Rosenn, the *jeitinho* is 'easier to describe than to define'. It is an 'ingenious maneuver that render the impossible, possible; the unjust, just; and the illegal,

[105] Alexandre Douglas Zaidan de CARVALHO, 'Brazilian Judicial Impartiality?' (2018) 2 Revista Jurídica da UFERSA 87

[106] Fernanda Duarte compiles similar social mechanism present in comparative literature like "the *trink-geld* in Germany, the *bustarela* in Italy, the *speed money* in India, the *baksheesh* in Egypt, the *mordida* in Mexico and the *vizyatha* in Russia. Bourdieu (1963) (cited in Barbosa, 1995: 38) mentions a practice that resembles the *jeitinho* known as *chtara* among the working class of Algeria. In Latin America, practices such as the *palanca* in Colombia (Albert, 1996: 335), the *pituto* in Chile (Juan Salazar, personal communication; 29 September 2005) and the *guaperia* in Cuba (Barry Carr, personal communication; 1 November 2003)" Fernanda DUARTE, 'Exploring the interpersonal transaction of the Brazilian jeitinho in bureaucratic contexts' (2006) 13 Organization 509 pg. 511

legal'[107]. *Jeitinho* is a response to a personalistic society of cordial men, through which the law is by-passed using friendliness and flexibility. It is not to be mistaken for the 'do you know who you are talking to' described in section 2.2 above. In fact, the *jeitinho* can be understood as a compensatory behaviour, a form of dealing with a draconian legal system[108], in which the powerful and rich have advantages over the rest. It is, according to DaMatta, a half-way, a mediation between the formal and the informal, embodying the cordial, conciliatory spirit of a 'young tropical country, full of possibilities'[109].

The *jeitinho* humanises institutions and equalises situations of deep inequalities. It is democratic insofar as anyone has access to the Brazilian *way*, not only the rich and powerful. However, Lívia Barbosa suggests a paradoxical facet to this ritual[110]. Even though it is a trace of the adaptability and informality of the Brazilian, the *jeitinho* is also used in formal situations, like asking a bureaucrat to bend the rules, pulling some strings so that a rigid formal procedure can be accelerated or *dodged*. For example, in the context of health care litigation, one litigant from Campinas, São Paulo, describes a typical situation where the Brazilian *way* and personalism were used in her/his favour. (S)he needed a drug that was not supplied in the public system (SUS) and so (s)he started a legal action against the municipality to access it. When the interview took place, the case was still not over, however she/he expressed feeling optimistic about the chances of getting it:

> [Another option to litigation] would be buying the drug and asking for a refund from the state. So, because I work at the Secretary of Health care in my city, I talked to the Secretary, and he told me that if I had to buy the drug, he would find a way to reimburse me via Secretary [of Health care][111]

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[107] Keith S ROSENN, 'Brazil's Legal Culture: The Jeito Revisited' (1984) 1 Fla Int'l LJ 1

[108] 'The Portuguese fondness for form over substance rooted firmly in Roman and Canon law, resulted in an incredibly formalistic legal system... Under the Portuguese legal system, the Crown pretended to rule and the subjects pretended to obey' (Norman NADORFF, *O Jeito na Cultura Juridica Brasileira* (JSTOR 2001)) pg. 607

[109] DE HOLANDA, *Roots of Brazil*

[110] Lívia Neves de H BARBOSA, 'The Brazilian jeitinho: An exercise in national identity' (1995) The Brazilian puzzle: Culture on the borderlands of the Western world 35

[111] Interview conducted in Campinas, São Paulo, on December 12th, 2016.

Like the case mentioned above, where the litigant found a solution outside the formal processes, most Brazilians agreed having used a *jeitinho* at least once. Using a *way* does not necessarily mean breaking the law, as in the case of corruption, for example. However, the term brings with it negative connotations, of a people who is not serious, who do not follow the law and thus are not worthy of trust. Therefore, as a major item of the Brazilian identity, the *jeitinho* is also part of the image of Brazil constructed by Brazilians, who become suspicious of their fellow countrymen, particularly when relationships of power are at stake.

I proposed an analysis of the phenomenon of health care litigation from all of these nuanced angles of the *jeitinho*. As I unpack in Chapters 4 and 5, the majority of interviewed judges, public officials, lawyers, and public defenders agree that judicialising the health care policy is either a *wrong* way around a systemic problem (of a perceived corrupt and inefficient state), or, at least, not the best legal solution to a structural issue. However, most also expressed the opinion that health care litigation is a *necessary evil vis a vis* the magnitude of the political/policy problems in Brazil. According to these interviewees, due to the inequalities of the country, the difficult situation encountered by most Brazilians who do not have access to good quality health care, and in the face of a system that is corrupt, or inefficient, and which will hardly be changed in the short-run, people need to find a way. A way to equalise the situation of those who need and do not have, to those who dominate economic/political power or the economy, a different, unique way around the problem.

The Brazilian *jeitinho* has three interconnected dimensions[112]. The first is the cordial person archetype of Sergio Buarque de Holanda and refers to a perceived Brazilian way of relating to others (i.e., observed by the tendency to be charming and affectionate). The second

[112] Fernanda DUARTE, 'The Strategic Role of Charm, Simpatia and Jeitinho in Brazilian Society' (2011) 24 라틴아메리카연구 29

relates to the flexibility and creativity present in the Brazilian way of solving problems, typical of the *jeitinho*. And the third and final one refers to the rebellious social practice of bending or breaking the rules to 'get things done', or in the words of DaMatta 'a clever dodge or bypass'.

As mentioned above, part of the reason why Brazilians had to develop creative ways around the draconian socio-legal reality comes from the fact that the formal system of government and the norms were based on a foreign ideal, not applicable to the reality of Brazilian society. The formal thus becomes a narrative, used to disguise the social praxis.

2.4 A History of Brazil and the [inter]national stories: how formal discourses are used to disguise the social praxis

Figure 3: America

 [113]

A singular event which marked the history of Brazilian colonisation under the Portuguese crown, and made Brazil's development different from its neighbours, was the

[113] Stephan Kessler, 'America', second half of the 17th century, Pinacoteca do Estado de São Paulo. This piece was commissioned by the Portuguese Crown and painted by Stephan Kessler, a German painter who never travelled to America. Based on descriptions sent via letters by Portuguese in the colony, Kessler portrayed what he believed to be the encounter between the Portuguese and the native indigenous peoples of America. Débora Alcaine, analyses the work on https://dlf.uzh.ch/sites/latinamerica/latinite-du-bresil-origines-fantasmees/, access on October 15th, 2019.

transfer of the Portuguese Empire capital to Rio de Janeiro. In November 1807, escaping from the invasion of Napoleon's troops, the Portuguese crown boarded a naval fleet on its way to Rio de Janeiro. As a consequence, from 1808 until its independence Brazil was made the capital of the Portuguese Empire. The abrupt transfer of the Portuguese Crown to Brazil brought with it 15,000 Portuguese citizens and had a tremendous impact on the country and society. The influence of the Portuguese royalty's presence in Rio is evident until this day, in the city's architecture and in the particular way the *carioca* people speak, their accent.[114]

More importantly, however, were the institutional changes brought with the arrival of Dom João and the Portuguese Crown. These impacted Brazil and how Brazilians related to public institutions until this day. Not only from the establishment of enduring institutions, such as the legal system and the official language, but also the social memory of a patrimonial elite that exploited the public power for personal interests. One contemporary mark of these colonial scars can be noticed, for example, in the generalised distrust shown by interviewees in relation to public authority and politics in Brazil. As I will explore in chapter 3, the generalised social perception that the state in Brazil, and its representatives, are corrupt and inefficient fuel a generalised distrust in public institutions - particularly those political in nature. This distrust impacts not only the perception citizens have about the state and how they relate to the public sphere, a theme further discussed in Chapter 6, but how public officials themselves, such as judges, act when performing their public duties. For example, judges expressed a tendency to distrust the arguments raised by the state when deciding health care lawsuits, which was confirmed by public attorneys. One judge mentions, for example, how (s)he cannot trust the argument of the public attorney that the state has no resources to pay for the inclusion of a drug in the health care policy, and thus cannot grant it to an individual patient:

[114] Angela Marina Bravin DOS SANTOS, *A suposta supremacia da fala carioca: uma questão de norma* (2013)

> When I say I don't trust the health manager, I'm not referring to the distrust of honesty. Although this is also a problem, unfortunately, in various times we discover cases of corruption, overpricing and embezzlement. But let's disregard this aspect for a moment. We have a bureaucratically inefficient state and when the state's defence talks about their inability to fund a drug, I think: are you telling me to trust someone who can't be trusted? So, is there a distrust of the Judiciary in relation to the Executive? Well, who does not distrust the Executive in Brazil, I think that is the question we need to ask. Is there someone who blindly trusts any public policy of the Executive? If the state was trustworthy, it would not be easy for me to grant the claims. But no one trusts the state, the state denies access to everything, claiming that they don't have a budget. It is inhumane, it is sadistic.[115]

I will further address the relationship between health care litigation and the social-historical background of Brazilian society in the empirical Chapters 3-7. In this chapter I focus on the historical and sociological background of Brazil in order to make a case for these connections, such as how the *stories* about the Brazilian identity help shape the social context.

Formal tales and the praxis of *jeitinho*

Soon after the Royal family docked in the country, Brazil had its first Royal Military, Art, Agriculture and Sculpture Academies founded. Royal Museums, the Royal press, a Brazilian Bank, and the High Court were also set up to serve the Crown. Public institutions were to carefully imitate the Portuguese bureaucracy, and people were to closely mimic the European ways. The independence came in 1822, and differently from other South American countries, it was negotiated between the elite and the crown and not fought for. Brazil continued to be ruled by the same Portuguese elite and by those chosen by the crown to protect the lands. Albeit independent, Brazil was still a monarchy, surrounded by Spanish speaking American republics from North to South. As Lilia Schwarcz explains, the transition from colony to an independent monarchy in Brazil went smoothly, as there were not many institutional

[115] Interviewee 24 (2016) Interview with appellate judge in São Paulo (SP) [14/12/2016]

innovations. However, there was a clear objective in sight for the government: to structure and justify the reasons for establishing a new nation, and 'inventing a new history for Brazil, given that ours was, so far, basically Portuguese'[116].

Accordingly, in 1844 the government opened a public competition for academics to write the history of the colony. The result set the foundations for what would later be known by Brazilians and taught in schools as *The History of Brazil* – which does not translate the full story of the country and its peoples. The public competition was won by a German, Karl von Martius, who knew little about Brazilian history, despite his academic expertise. However, Martius' story, told until this day by Brazilians, is a one-sided narrative. Not necessarily wrong; yet a fraction of the history.

Moreover, the story told through von Martius' narrative had the objective of mesmerising the Europeans with the natural wonders of Brazil and the harmony in which peoples of different origins lived in the country. However, this story did not account for the horrors of slavery, the abuse of power, the extermination of indigenous peoples, the inequality and the corruption. Thus, the other chapters of Brazil's story, which are not told in the formal tales of Europeans, are formed through the informal rapport of its people, and by the anthropologists and sociologists who bravely show us what lies beyond the pages of make-believe. But why does this matter to legal scholarship, health care litigation and judicial activism, one might ask? Because this vignette about how Brazilian history has been written is further indicative of Brazilians getting used to a disconnection between the formal narrative and the praxis of the 'real world'. The foreign, alien bureaucracy that was so difficult to navigate required a *jeitinho* around it – this dialectic dichotomy became the national identity. Thus, formal Brazil is not necessarily the real Brazil, as the story of Brazil told by Martius is not necessarily the whole history of Brazilians.

[116] Lilia Moritz SCHWARCZ, 'Sobre o autoritarismo brasileiro' (2019) São Paulo, Companhia das Letras

Race and prejudice in the construction of a Brazilian identity: the contrast between the rhetoric of the river and the praxis of slavery

> It's fundamental (…) to realise that national identity is a construction that the official intellectual discourse, the discourse of the nation-state, 'essentialises'. However, the fact is that that this identity, which is or may be an invention of the nation-state behind it, becomes 'real' after it is established (…). Racial democracy is certainly a myth [in Brazil], but it is also a dream in which most Brazilians of all colours and social classes want to believe with passion. At the same time that the myth denies [blacks] the reality of their own oppression, it also gives them the certainty of their inherent, fundamental equality, and reminds their oppressor how a good Brazilian should behave.[117]

The construction of Brazilian identity, as explained above, is embedded in a sense of duality; a constant push-pull of opposite forces between what Brazil is and what it should be. This tension can be identified between the *jeitinho* against the formal law and rigid bureaucratic procedures; the tales of an inclusive, peaceful, and joyous society against an unequal and oppressive one; and the myth of a racial democracy against a history of exploitation and prejudice against black peoples. This last one is a chapter of Martius' story about Brazil which haunts Brazilians until this day and informs the premises of its identity.

It is vital to understand that the story written by von Martius, which was commissioned by the Portuguese Monarch that ruled the now independent country, had a definite purpose: to confer legitimacy to the Portuguese colonisation and to the Monarch (which was questioned due to its contrast to the neighbouring republics). Von Martius thus hid the truth about the most enduring and cruel slavery in the world, the rigid hierarchy between races, and the mass murder of indigenous peoples in a tale about a river.

[117] Ronaldo HELAL and Cesar GORDON JÚNIOR, 'Sociologia, história e romance na construção da identidade nacional através do futebol' (2001) HELAL, Ronaldo A invenção do país do futebol: mídia, raça e idolatria Rio de Janeiro: Mauad 51 160

According to Karl von Martius' story, Brazil could be compared to a river, that when flowing down absorbed two confluent streams which then formed one single body of water, mixed and singular. The first river, the absorbing and cleansing one, was a symbol of the Portuguese coloniser, who mixed with the other two small rivers, symbols of the native indigenous peoples, and the Africans, brought to the country as slaves. That resulted in the mixed people of Brazil: a country that, according to that European narrative, knows no prejudice, segregation or sadness. A country where everyone is *cordial* and every day is *carnival*.

However, according to the brilliant analysis of Professor Schwarcz's book *About the Brazilian Authoritarianism*[118] (my own translation), this national myth invented by the foreigners, who knew little about Brazil, was merely a formalised, institutional narrative that sold to the world an ideal Brazil, hiding the truth about colonisation and slavery. As the Professor explains, the result of the Portuguese colonisation was far from this ideal and peaceful mix of races, it was the consolidation of profound social inequality and racism.

Although the discussion of race is not central to my research, what von Martius' story shows is how institutional narratives can be used to hide the social praxis. And how the duality of what 'is' and what 'should be' is always present in the structures of Brazilian society. In this case, the racism, prejudice and inequality resulting from centuries of slavery was hidden by a formal narrative enforced by the government which depicted Brazilians as a non-racist, peaceful culture. In the case of health care litigation, the formal law produces a narrative of constitutionalism whilst the social praxis unravels issues of distrust and inequality. These narratives can also be understood as institutional *jeitinhos* around a social praxis which must be hidden so that the *status quo* of those in power can remain the same[119].

[118] SCHWARCZ, 'Sobre o autoritarismo brasileiro'

[119] 'Until recently, the jeito was not considered a topic worthy of serious scholarly inquiry. As with the related institution of corruption, research on the jeito was considered taboo for lawyers and social scientists. This is partly

The centrality of the formal law and design of complex bureaucratic systems is also one pole in the duality against the friendliness and flexibility of Brazilians, present in the cordiality and *jeitinho*. This notion of dualities and tension are central to Brazilian social structures and must be kept in mind when analysing the health care litigation.

A powerful and overloaded Judiciary

The independence and power of the Judiciary are two key factors for understanding the increase in the judicialisation of politics and health care in Brazil. The Portuguese roots of the Brazilian Judiciary show important influences in this development. Moreover, the Judiciary was a key part of the Portuguese and Spanish empires, insofar as the resolution of conflicts was considered a true extension of the king's powers[120]. In the colonial Brazil, however, much of the conflicts in Brazil were resolved extra-officially by local authority and landowners. It was only after the establishment of the Republic that the Judiciary gained institutional relevance.[121] Until the Constitution of 1934, the nomination for the offices of judge were politically made, and thus deeply influenced by personal connections – which reinforced the personalist trend of power distribution and reinforced the conservatism of the courts[122].

In the 1930's, during the bureaucratic reforms proposed by Getúlio Vargas one major creation revolutionised the public official profession: the requirement of public examinations (*concursos públicos*) for the selection of public officials, including judges. These examinations

attributable to the bias of Brazilian law schools against empirical research and in favor of classical exegesis of legal texts' (ROSENN, 'Brazil's Legal Culture: The Jeito Revisited', 4).

[120] Stuart B SCHWARTZ, *Burocracia e sociedade no Brasil colonial: o Tribunal Superior da Bahia e seus desembargadores, 1609-1751* (Companhia das Letras 2011)

[121] Maria Tereza SADEK, 'A organização do Poder Judiciário no Brasil' (2010) Uma introdução ao estudo da justiça

[122] Francisco Ney Carvalho ARAÚJO JÚNIOR, *As raízes do poder judiciário brasileiro: uma análise acerca da burocracia do sistema judicial no período colonial* (2016)

are seen as a way of selecting the best candidates through impersonal processes based on strictly technical standards. Even though the literature points out the political bias, conservatism and elitism present in the elaboration of these examinations[123], there is a definite notion of legitimation which arises from passing a difficult test. The *concursados* (those approved in public examinations) are not only seen as legitimate choices for fulfilling the roles, but there is also a sense of a superiority in contrast to other public officials who did not go through the examinations – i.e., politically appointed and elected officials. Accordingly, a Supreme Court judge reflects during his/her interview:

> [T]he Judiciary is more qualified and better than the other powers of the Brazilian democracy. To enter the judicial family as a judge, prosecutor or public defendant, one has to attend law school (…) and be approved in a public examination. The public examination to become a judge is serious and difficult, creating a minimum standard of qualification for judges. That does not take place in the Legislature.[124]

According to the judge from the highest court of the country, the fact that judges, prosecutors and public defenders passed a difficult examination is an indicator of their technical superiority, which would confer legitimation to decide matters that, in theory, would be of the Executive's responsibility – such as including a drug in the SUS approved list of drugs. This theme is further explored in Chapter 4.

To the perceived technical superiority of the Judiciary '*family*', as the justice puts it, is added the constitutional protection of the Judiciary's independence for self-regulation and governance. But this was not always that case. The vast powers and protections offered to the Judiciary in the 1988 Constitution were a response to the authoritarian past of the country.

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[123] Marcelo Maciel RAMOS and Felipe Araújo CASTRO, 'Aristocracia judicial brasileira: privilégios, habitus e cumplicidade estrutural' (2019) 15 Revista Direito GV ; Dartagnan Ferreirra DE MACÊDO, Carolina Maria Ferreira GOMES, Antonio Carlos Silva COSTA *and others*, 'Análise do concurso público como instrumento de seleção de pessoal no setor público: percepção de um grupo de servidores de instituições federais de ensino superior' (2016) 29 Revista Sociais e Humanas 92

[124] Interviewee 2 (2016) Interview with a Supreme Court judge in Brasília (DF) [16/11/2016].

During the military dictatorship that ruled the country from 1964 to 1985, the powers of the Executive were strengthened, leaving the Judiciary and the Legislature as sub-institutions[125]. The suppression of individual rights and of the reduction of the judicial powers during the military regime had an important counter-effect during the process of re-democratisation. As a response to a period of constrained individual rights and a tamed Judiciary, the Constitution of 1988 thoroughly protected individual rights, promised social rights and guaranteed the independence of the Judiciary, financially and administratively. That happened with a lot of pressure from the legal elites during the Constituent Assembly, though[126].

When analysing the constitutional processes in Latin America, Roberto Gargarella talks about how the so-called 'new constitutionalism' only reinforced the power structures that were already present in the XIX century[127]. Accordingly, that is what happened to the judicial power in the Brazilian Constitution of 1988 – an expansion of the powers of an elite of lawyers that have ruled the country since the 1500.

Under the current constitutional framework, the administrative independence of the Judiciary in Brazil means that judges are not only safe from the political pressure of other public spheres, but that they are also responsible for their own internal organisation. As an example, in the modern Brazilian Judiciary the selection process for judges and public officials

[125] SADEK, 'A organização do Poder Judiciário no Brasil'

[126] 'The legacy of opposition to military rule played out in the institutional framework created by the 1988 Constitution, which guaranteed a high degree of judicial independence, greater public access to the high court, and the creation of new case types aimed at constraining Executive arrogation of power. Legal groups such as the OAB saw their opposition to the military and defence of democracy rewarded with new forms of access to the courts. But as Steinmo, et al. suggested, institutions may shape not only political actors' strategies, but their very goals. The very important position of the Judiciary and lawyers in drafting the extensive democratic rights incorporated in the Constitution, the related preferences these groups have strongly voiced in years since, and the resulting manner in which the judicial system is used, have placed the Brazilian Judiciary on a collision course with the Executive branch's reformist goals at key moments over the past fifteen years.' (Matthew M TAYLOR, 'Citizens against the state: the riddle of high impact, low functionality courts in Brazil' (2005) 25 Brazilian Journal of Political Economy 418)

[127] Roberto GARGARELLA, *Too much "Old" in the "New" Latin American Constitutionalism* (Artigo apresentado no Seminar in Latin America on Constitutional and … 2015)

of courts is done via *concursos* conducted by the courts themselves. Furthermore, the prosecution for administrative faults eventually committed by judges are also conducted by the Judiciary.

The independence and strength of the courts was further increased in 2004, through the constitutional amendment 45 which created the National Council of Justice (CNJ) and gave the Supreme Court the power to produce binding jurisprudence, an impacting innovation for a civil law country – which, as mentioned above, is contested by some as unconstitutional.

2.5 Conclusion

To conclude, the sociological background presented in this chapter sought to provide insights about the social structures established in Brazil since its colonisation in 1500 which still have an impact during contemporary days. Through a brief historical overview of how the relationships of power between the state and citizens, and the distribution of resources were developed in Brazil I provide a background to understand why and how contemporary judicial politics take place. I specifically focused on the following key themes which are essential to understanding the socio-legal factors which drive health care litigation in contemporary Brazil: (i) the constant duality between the social praxis and the formal discourse (what Brazilians are and what they think they should be). This tension is observable in most structures of society in Brazil, which is why the 'law on the books' must be borne in mind as much as the 'law in action'; (ii) the development of a personalistic, clientelist and patrimonial society, where the resources (both economic and political) are concentrated in the hands of few, and used as tools of negotiation for private gain; (iii) the cordial men, which entails the friendliness of Brazilians and familiarises formal relationships; (iv) the *jeitinho* which provides a way around the rigidity and formality of the bureaucratic systems, a form of compensation for the inequalities present in the social structures.

These insights serve as a framework which can be used to contextualise and explain the health care litigation phenomenon studied here. By tying the analysis of empirical data about health care litigation with the themes referred to above, I am able to provide a more comprehensive understanding of the health care litigation phenomenon beyond a focus solely on the formal law. In the next Chapter I analyse the external socio-legal factors which mainly influence judges' decisions to grant health care claims.

CHAPTER 3 – THE IMPACT OF INTER-INSTITUTIONAL DISTRUST ON JUDICIAL DECISIONS IN HEALTH CARE LITIGATION: USING THE BRAZILIAN WAY (*JEITINHO*) AROUND A 'BAD' GOVERNMENT

Figure 4: Graffiti in São Paulo

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> [There is a] total mistrust [in the government]. An idea of total inefficiency, mismanagement and corruption[129]

Some 2,500 years ago, Confucius taught that for a government to withstand time it needed three basic elements: food, weapons and *xin* (trust)[130]. When questioned by his disciple Zigong about which of three elements one should keep if (s)he could not hold on to all three of them, Confucius replied that *xin* should be the one value that ought to be guarded to the end. Without it the common people and its government could not stand, answered the teacher[131].

Trust, as considered in modern times, is a much wider concept than that of *xin*, developed in the Confucian ethics. *Xin* is understood in modern trust concepts as an

[128] The photo shows a man graffitiing a street wall in São Paulo with the saying: "Brazil… where graffiti is a crime and corruption is an art!" (Available at www.flickr.com/photos/mr-morby/6499064477 access on May 19th, 2020)

[129] Interviewee 38 (2017) Interview with first-degree federal judge from São Paulo (SP) [22/01/2017].

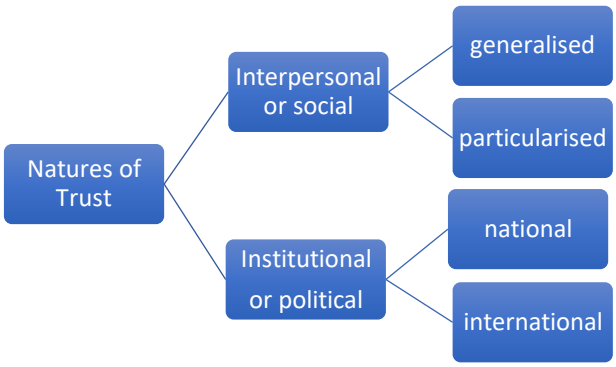
[130] Onora O'Neill, *A question of trust: The BBC Reith Lectures 2002* (Cambridge University Press 2002) 3

[131] Kam-por YU, Julia TAO and Philip J IVANHOE, *Taking Confucian ethics seriously: Contemporary theories and applications* (Suny Press 2010)

interpersonal trustworthiness, a quality present in those who comply with a *verbal contract* by keeping their word[132].

Nowadays the application of 'trust' has extended far beyond the interpersonal relationships referred by Confucius as *xin*. One of the proposed divisions of trust relationships refers to the nature of the link between those who trust (the trustor) and the trusted object, as represented in the following diagram:

Figure 5: Typology of Trust Relationships



[133]

According to this representation of trust, it can be developed in relationships which are interpersonal in nature – i.e., between an individual and a specific other, or social in nature – based on situations or structures which are not particular to one individual or to an individual relationship, but generalisable to a wider group. Moreover, in the case of interpersonal trust relationships, the rapport is based on the interaction between two individuals, horizontally. This type of trust can then be further subdivided in particularised trust, which refers to relationships

[132] Cecilia WEE, '" XIN", TRUST, AND CONFUCIUS'ETHICS' (2011) Philosophy East and West 516 99

[133] Diagram based on the overarching concepts of trust developed by D Harrison MCKNIGHT and Norman L CHERVANY, *Conceptualizing trust: A typology and e-commerce customer relationships model* (IEEE 2001)

between persons within the same family or kinship relations, and generalised trust, when the trusted person is unknown or not closely related to the trustor.

Trust can also relate to the relationships between the trustor and an institution. This type of trust is one of a vertical nature, referred to as institutional or political trust, and can also be subdivided into national and international institutional trust. A common trait between both interpersonal trust – as found in *xin* - and institutional trust, are its roots, which reside in the trustor's *expectations.*[134]

Transporting these notions to the case study of health care litigation in Brazil, the expectation which underpins the trust relationships is rooted in article 196 of the Brazilian Constitution and its interpretations.

Moreover, from the interpretation of the constitutional text by courts, the legal literature and political elite, Brazilian citizens developed the expectation of having access to a universal and free health care system. The extent of that expectation, however, depends on understanding what the constituent power defined as *universal* (article 196) *and integral* (article 198, II)[135] access. While some believe that by *integral access (full service)* the Constitution refers to the right to access *any* treatments and drugs, others read the article in a more restrained manner, limiting the concept of *integral and universal* with reference to the limits imposed upon the constitutional right, statutory provisions and regulations. My interest in this chapter is to understand why judges and litigants interpret such constitutional provision in one way or another – i.e., more restrictively or more widely. In other words, in this chapter I unpack the

[134] John ERNISCH, Diego GAMBETTA, Heather LAURIE *and others*, 'Measuring People's Trust' (2009) 172 Journal of the Royal Statistical Society 749; T. K. DAS and Bing-Sheng TENG, 'The Risk-Based View of Trust: A Conceptual Framework' (2004) 19 Journal of Business and Psychology 85

[135] Article 198. Health actions and public services integrate a regionalized and hierarchical network and constitute a single system, organized according to the following directives: (CA No. 29, 2000; CA No. 51, 2006; CA No. 63, 2010) I – decentralization, with a single management in each sphere of government; II – full service, priority being given to preventive activities, without prejudice to assistance services; III – participation of the community

socio-legal factors which inform these different interpretations of a general right to health care according to the interviews conducted with health care litigation actors in Brazil.

According to a representative of a patients' association:

> The Constitution is very clear, [providing] health care is a state's duty and a right of everyone, period. It does not matter if the medication is cheap or expensive[136]

And with a different point of view, a representative of a pharmaceutical company reflects:

> The medical doctor wants the best treatment for his/her patient; but sometimes the best treatment in the market cannot be offered [by the public system]. Especially in a country like ours, which is mostly underdeveloped.[137]

The quotes above exemplify how actors read the constitutional right to health care in different lights. While, on the one hand, some people defended the universality and integrality of health care as the entitlement to receive any drug or treatment, no matter the cost, on the other hand some interviewees understood that the Brazilian public health care policy is unable to attend to every health treatment offered by the industry, and that the citizens' expectations should be adjusted to meet the limited budget destined for the health care policy.

Thus, the interpretation of the constitutional text will determine people's expectations of how much the public health care system should provide to Brazilians. These expectations are also informed by people's perceptions of the political system and of their entitlements as citizens, which in turn are informed by their experiences and knowledge - personal or those of

[136] Interviewee 10 (2016) Interview representative of a patient's association in São Paulo (SP) [23/11/2016].

[137] Interviewee 41 (2017) Interview with representative of a pharmaceutical company in São Paulo (SP) [26/01/2017].

relatives and close friends.[138] In the case of public health care, the perceptions expressed by interviewees were usually aligned with the earlier experiences, meaning that if someone had a positive experience in a public hospital, for instance, (s)he tended to have a better perception of the health care system in general.[139] The same happened for bad experiences.

However, several of the interviewees never had a personal experience with the public health care system. Moreover, according to the National Agency for Supplementary Health care (ANS), as of March 2020, 22.5% of Brazilians had private insurance[140]. This means that around 47 million Brazilians make use of the private system, and thus had little or no experience with the public system.[141]. Amongst these are public servants, like judges and prosecutors, who are entitled to private health care insurance paid for by the Judiciary. These people cannot rely on their own knowledge or experience of the public health care system and thus end up relying on external sources to inform their opinion about the system. Furthermore, previous experience with a public policy can influence how that person will relate to other policies from the same government, such as health care or education[142].

[138] Max KAASE, 'Interpersonal trust, political trust and non-institutionalised political participation in Western Europe' (1999) 22 West European Politics 1

[139] Tracey S DAGGER and Timothy K O'BRIEN, 'Does experience matter? Differences in relationship benefits, satisfaction, trust, commitment and loyalty for novice and experienced service users' (2010) 44 European Journal of Marketing 1528; Staffan KUMLIN, 'Institutions—experiences—preferences: How welfare state design affects political trust and ideology', *Restructuring the welfare state: Political institutions and policy change* (Springer 2002)

[140] Information available at https://www.ans.gov.br/perfil-do-setor/dados-gerais accessed on May 19th, 2020.

[141] According to a statistical research about the sociodemographic profile of SUS users, 67,3% of SUS users were non-white, 73% had only basic education, 79,9% did not have private health care insurance and only 13,8% had private insurance (Zilda Pereira DA SILVA, Manoel Carlos Sampaio deAlmeida RIBEIRO, Rita Barradas BARATA *and others*, 'Socio-demographic profile and utilization patterns of the public healthcare system (SUS), 2003-2008' (2011) 16 Ciência & Saúde Coletiva 3807).

[142] Analysing how perceptions about the quality of water management are formed, França Doria affirms that that factors such as trust in suppliers, past problems attributed to water quality and information provided by the mass media or interpersonal sources are essential in the formation of opinions about the quality of water supply (Miguel DE FRANÇA DORIA, 'Factors influencing public perception of drinking water quality' (2010) 12 Water policy 1). In another study, about the impact of transport restriction policy and evaluation of local government, Christiansen found that citizens who were unhappy with the transport policy showed dissatisfaction when evaluating the overall performance of local government and other political choices (Petter CHRISTIANSEN,

These distinctions can be perceived when comparing the statements made during interviews by users of the public health care system and non-users[143], such as judges, lawyers or prosecutors. On the one hand, when talking about their own experiences, the public health care system (SUS) users usually describe specific, tangible problems witnessed by themselves or close relatives/friends – i.e., problems like long waiting periods to schedule specialist appointments or long queues at emergency units, lack of beds in hospitals and shortage of medical practitioners. Two of the doctors I interviewed, for example, mentioned specific problems like unavailability of medical doctors and nurses in the emergency units they served as practitioners and long waiting queues in the public hospitals, referring to their own experiences and those of colleagues in other public hospitals[144].

Nevertheless, when the interviewees were non-users of the SUS or the question asked related to a broader evaluation of the health care policy, one that people could not relate to their direct experience, then answers tended to refer to wider, less palpable issues, such as corruption, bad politics, lack of will on the administrators' side to improve the health services, and lack of technical skills amongst politicians and Executives. The further away people were from personally experiencing the issues debated, the stronger were their perceptions of a lack of quality in the system in general, and their perceptions were more associated to wider political issues, such as corruption, and less to tangible health care issues, like waiting time and understaffing. A public attorney whom I interviewed commented on how the judge's lack of

'Public support of transport policy instruments, perceived transport quality and satisfaction with democracy. What is the relationship?' (2018) 118 Transportation Research Part A: Policy and Practice 305).

[143] As it is developed in Chapter 2, the Brazilian public system is mainly used by people of low-income. Studies show that the usage of the public system increase is inversely proportional to the income increase (refer to: Zilda Pereira da SILVA, Manoel Carlos Sampaio de Almeida RIBEIRO, Rita Barradas BARATA *and others*, 'Perfil sociodemográfico e padrão de utilização dos serviços de saúde do Sistema Único de Saúde (SUS), 2003-2008' (2011) 16 Ciência & Saúde Coletiva 3807 and Ana Maria Nunes DE FARIA STAMM, Rangel OSELLAME, Fabricio DUARTE *and others*, 'Perfil socioeconômico dos pacientes atendidos no Ambulatório de Medicina Interna do Hospital Universitário da UFSC' (2002) 31 Arquivos catarinenses de medicina 18).

[144] Interviews conducted with medical doctors that work both in the public and private systems in São Paulo on January 14th, 2017, and January 22nd, 2007.

personal experience with the public health care system (SUS) interferes in the way (s)he perceives the quality of the system:

> The judge comes from a social status that had no contact with SUS, (s)he never went to SUS, or hardly came close to it. What (s)he knows about the SUS is what (s)he sees on television (…) in the newspaper, which is usually depicting the hospitals in Rio de Janeiro that have the worst numbers, where chaos is installed, (…) with images of people laying on a stretcher in the hospital corridor, sometimes on the floor. So, this is their view of the system. Added to the experience of what comes to them [in the lawsuits]. When judges receive a lot of lawsuits requesting drugs or procedures (…) [it informs] his/her vision of the problem. (…) It is an absolutely distorted reality I think, because they can't see the big picture from their desk.[145]

Summing up, according to literature, and confirmed in the 55 interviews conducted in Brazil with actors involved in the health care litigation phenomenon, people's trust in institutions depends on their (i) expectations of what the constitutional 'right to health care' provision entails (in the access of drugs, treatment and health devices context) – illustrated for example, by the fact that some people say they have the 'right' to get any treatment (ii) their expectation of the public health service itself, which encompasses their experience or lack thereof with the public health care system, and (iii) the contextual situation they find themselves in – i.e. the inhabitant of a city which is poorer or has a worse health care system will tend to perceive the overall system as bad. This was illustrated by statements of judges in Rio de Janeiro who compare the tough reality of the communities they are in with the ones from São Paulo – a richer state, with better health care. According to them, this discrepancy could explain why judges in Rio de Janeiro are more prone to granting health care claims[146].

[145] Interview with public attorney from Santa Catarina on February 3rd, 2017.

[146] Interviewee 16 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016] and Interviewee 17 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

The result of this cognitive process[147] which encompasses people's expectations, their experiences, and perceptions of the external and internal factors, has a bearing on how they behave, i.e., deciding to start legal action in the case of litigants, to grant claims in the case of judges, all of this feeds into interpretations of what a 'universal right to health care' entails in the Brazilian constitutional context, in the case of courts interpreting the constitutional law.

We must bear in mind, however, that there are nuances to all three elements mentioned above - expectations, experiences and perceptions. These nuances can be the result of the different socio-economic background of the interviewees (indicated, for example, by their schooling level and place of residence, their profession, use of public defender or private attorney). As mentioned before, in Brazil richer people (including judges and civil servants) tend to have less personal experience of the public health care service, as they usually make use of the private care, via private insurance or self-payment. Therefore, their perception of the public system is unsurprisingly different from those who have used it. The quality and access to public health care also varies between federal states and regions[148]. For example, people in the countryside have less access to specialised health care treatments, given that speciality hospitals are usually located in the capitals. This reflects on the perception developed by user of the health care system in the capitals and in the countryside, which in turn have consequences of how non-users of that same region – for instance, judges – perceive the system. Moreover,

[147] For further exploration of the concepts of cognitive processes and how it affects trust: Bradley J OLSON, Satyanarayana PARAYITAM and Yongjian BAO, 'Strategic decision making: The effects of cognitive diversity, conflict, and trust on decision outcomes' (2007) 33 Journal of management 196 and Claire A HILL and Erin Ann O'HARA, 'A cognitive theory of trust' (2006) 84 Wash UL Rev 1717

[148] The number of doctors per inhabitant in the capital of Pará and Amazonas reaches ten times the numbers of doctors per inhabitant of countryside cities (Rodrigo Pinheiro SILVEIRA and Roseni PINHEIRO, 'Entendendo a necessidade de médicos no interior da Amazônia-Brasil' (2014) 38 Revista Brasileira de Educação Médica 451). The same disparity can be observed amongst the richest and poorest areas of São Paulo. Regions which concentrate 9.3% of the population of the municipality have more than 60% of the ICU beds of SUS. Meanwhile, 20% of the population (2.3 million people) live in seven regions (Parelheiros, Cidade Ademar, Campo Limpo, Aricanduva, Lapa, Perus, Jaçanã) - located on the outskirts of the municipality - where there is not a single bed (information available at https://datasus.saude.gov.br accessed on May 19th, 2020)

judges will hear claims from residents of that area, who will report the lack of doctors or specialised treatments. Two first-degree judges, one from the countryside of Rio de Janeiro and one from the countryside of São Paulo, illustrate this discrepancy between the capital and the countryside:

> If the people in the centre of Rio de Janeiro cannot get the spontaneous supply of medicines, imagine in the countryside… (...) In my city I am responsible for five competences, but it is not uncommon that I spend weeks working only on health care. When the municipality has no medicine in the public pharmacy, I know immediately, because I am unable to work on anything else. And when a medicine is lacking, we find out the next day.[149]

> Here [in the countryside] we don't have any of the special treatments. The countryside always comes second. So, it may be that if this [treatment] works in São Paulo, it may get here someday. But for now, we have none of that.[150]

As a result of all these nuances, the end-result of trust will inevitably vary in nature and intensity amongst different sections of the population. How does trust, then, influence the increase of successful health care litigation in Brazil?

While on the one hand judges expressed a distrust in the policy maker and the public health care policy in general, based on a cultural construction that, in general, public services in Brazil are bad – thus usually not grounded in specific data or personal experiences, on the other hand, when asked about how (and if) trust had influenced their decision to start legal action, litigants manifested a different kind of trust, one based on the outcome of the litigation process (explored further in Chapter 6). This does not mean that litigants conveyed trust in the ethics of politicians and did not perceive the Brazilian government and politicians as corrupt or inefficient, but these perceptions did not directly influence their decision to start legal action. They cared about the outcome of their case. ‘I don’t trust judges, but that did not influence my

[149] Interviewee 17 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

[150] Interviewee 32 (2017) Interview with first-degree judge in Campinas (SP) [16/01/2017]

decision. I needed the milk and, because of the other girls, the other experiences, I was certain I would get it'[151].

3.1. What is trust, inter-institutional trust, and why does it matter?

> I think so there is a total distrust [of judges in ANVISA]. When I go to a judge to discuss a case, I realise that the problem is not the subject of that particular lawsuit [that we are discussing]. They touch upon other problems that ANVISA presents, they talk about other matters as if they wanted to discuss all agency's activities, not only the object of the specific legal claim. They are evaluating the performance of the entire agency. The Judiciary is always suspicious [of ANVISA][152].

Trust is an essential element of cooperative behaviour[153] and, as such, an important social capital[154]. Its manifestation or lack thereof has influence on all social relationships[155], can break or make enterprises and affect the adherence to public policies.

Despite the wide range of literature written on trust, scholars have found it difficult to develop a general theory and overarching definition of trust[156]. I do not intend to provide a unique definition of trust, by going into in-depth discussion about its elements, but rather draw the concept from the sociological literature in order to apply it to the analysis of health care litigation in Brazil. By taking from the different concepts of trust developed by the literature, which are discussed throughout this chapter, I select those relevant to the themes brought up

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[151] Interviewee 20 (2016) Interview with litigant in Rio de Janeiro (RJ) [09/12/2016].

[152] Interview with ANVISA's public attorney in Brasília on November 18th, 2016.

[153] Niklas LUHMANN, *Trust and power* (John Wiley & Sons 2018)

[154] Robert D PUTNAM, Robert LEONARDI and Raffaella Y NANETTI, *Making democracy work: Civic traditions in modern Italy* (Princeton university press 1994)

[155] "Trust is seen to include both emotional and cognitive dimensions and to function as a deep assumption underwriting social order. Contemporary examples such as lying, family exchange, monetary attitudes, and litigation illustrate the centrality of trust as a sociological reality." (J David LEWIS and Andrew WEIGERT, 'Trust as a social reality' (1985) 63 Social Forces 967)

[156] Seligman, Gambetta and Maloy for example, stress the lack of cohesion in the literature regarding a concept of trust, and the problems that creates for empirical analysis: J. S. MALOY, 'Two Concepts of Trust' (2009) 71 The Journal of Politics 492; Adam B. SELIGMAN, *The Problem of Trust* (Princeton University Press 2000); ERNISCH, GAMBETTA, LAURIE *and others*, 'Measuring People's Trust', Frédérique SIX and Koen VERHOEST, 'Trust in regulatory regimes: scoping the field', *Trust in regulatory regimes* (Edward Elgar Publishing 2017)

during my interviews, in order to analyse the relationship of trust and health care litigation. Therefore, I start from the analysis of judges' and litigants' accounts of trust in the health care system in Brazil to then explore how those relate to the concepts of trust and distrust discussed in the social psychology literature.

Going back to the notion of *xin* present in Confucian ethics, which, as said, essentially refers to interpersonal relationships and verbal contracts, trust in modern days progressed to a more overarching concept that encompasses, beyond the relationships amongst people, those between people and institutions[157]. For example, do citizens in a country trust their legal system? What about their politicians?

As Onora O'Neill explains[158] there are different forms of trust and trustworthiness, and the trusting relationship is a dynamic one, and constantly evolving. Trustworthiness can be measured as the honesty and accuracy of truth claims, an assessment which is done empirically – i.e., is the Secretary of Health being honest when stating that the public budget destined for health care cannot include expensive medication - or it can relate to commitment, reliability, competence and expertise, all of which normative assessments – i.e., do I trust this lawyer to represent me in a litigation? Is he competent? Does he know enough about health law?

For example, when a judge says that 'there is an unnecessary bureaucracy and public officials are not ready to deal with the complexity'[159] (s)he is judging the competence and reliability of the health care authorities. When another judge says that 'they say there is lack of

[157] "The nature of this interaction makes a substantial difference, reflecting to a certain extent the distinction found in the literature between interpersonal trust and systemic trust (as in institutions)." (Max Kaase, Interpersonal trust, political trust and non-institutionalised political participation in Western Europe [1999] 22(3) Western European Politics 1-21, 3)

[158] Onora O'Neill, 'Linking trust to trustworthiness' (2018) 26 International Journal of Philosophical Studies 293

[159] Interviewee 50 (2017) Interview with Superior Court of Justice judge in Brasília (DF) [07/02/2017].

money due to the shady political pressure they suffer'[160], then (s)he is judging the honesty of the public official's claim that there is no money. Both, however, have an impact on trust. A negative one.

Furthermore, D. Gambetta defines trust as 'a particular level of the subjective probability with which an agent assesses that another agent or group of agents will perform a particular action'[161]. What we can generally conclude from this concept is that despite the different natures of trust, it will always involve cognitively administering and fulfilling one's *expectations* (trustor)[162] that a third person (the trusted actor) will deliver what was promised or that he/she will apply his/her best efforts to do so. This same logic can be thus extended to the notion of 'social trust'[163], which encompasses the expectations placed in a generalized other - an institution (i.e., the law or a public policy) or a public authority (i.e., politicians and courts). The question that must be asked when thinking about institutional trust is what does the person who is trusting expect from the trusted person or institution? For example, what do Brazilian citizens expect from the public health care system?

As said above, trust is not a static relation; it builds dynamically based on the actions and reactions of the agents involved. This means that when the trusted actor positively responds to the trusting actor's expectations (s)he is encouraged to reinforce that relationship and act on it (behavioural trust)[164]. In the case of health care litigation, when a litigant files a claim for

[160] Interviewee 24 (2016) Interview with appellate judge in São Paulo (SP) [14/12/2016].

[161] D. Gambertta, *Trust, Making and Breaking Cooperative Relations* (Basil Blackwell, 1988) 101.

[162] Das and Teng refer to the assessment of the probability that the person will perform as expected 'subjective trust' (T. K. Das and Bing-Sheng Teng, The Risk-Based View of Trust: A Conceptual Framework [2004] 19(1) Journal of Business and Psychology, 85-116)

[163] 'Social trust deviates fundamentally from individual trust, because the trust is expanded to include people about whom the trusting party has no direct information. Thus, social trust reflects a positive perception of the generalized other' [Gert Tinggaard Svendsen, *Trust* (Reflections 1, Narayana Press 2014)]

[164] S. C. Curral and T. A. Judge, Measuring trust between organizational boundary role persons [1995] 64 Organizational Behavior and Human Decision Processes, 151-170.

access to drugs, treatments or medical devices and the claim is granted, this person enhances their trust in the legal procedure, making them more inclined to litigate again or recommend litigation as a form of conflict-resolution. According to a litigant from Campinas:

> I filed some lawsuits with this lawyer and saw that my problems were resolved. So, when I needed it again, I will litigated again. (…) All the legal cases that I asked the lawyer to start for me always worked, and quickly. So, until this day I trust the Judiciary[165].

This *utilitarian* notion of trust will be further explored in chapter 6 with reference to the idea of individualism and the wider issue of the relationship of Brazilians with public power.

Again, it is not the main goal of this research to find out if the perceptions of trustworthiness[166] expressed by interviewees match the real quality of the health care service – which is a hard task in itself. Here, the focus in on *how* these perceptions influence actors' behaviour relating to litigation; how perceptions of the system factor in their decision to start legal action and grant claims.

3.2 Perceptions of quality of government in Brazil

> Health care litigation seems to me to be a symptom of a public policy that, since its planning phase, is not well. […] If I was a judge and a citizen came to me saying that (s)he had no access to health care, no access to education, I would also grant the request. Why? Because in reality the government, starting with the Executive power, only offers short term solutions to structural problems that would demand a much more sophisticated diagnostic.[167]

To explore how perceptions of quality of government are formed we must understand the political framework and social structures of a country.[168] In other words, besides the legal

[165] Interview with litigant from Campinas, São Paulo, on January 26th, 2017.

[166] O'Neill, 'Linking trust to trustworthiness'

[167] Interviewee 28 (2017) Interview with public attorney for the Secretary of Health in São Paulo (SP) [12/01/2017].

[168] For a deeper understanding of the concept of institutions as well as its placement within a larger societal frame and organisational dynamic: Alejandro PORTES, 'Institutions and development: A conceptual reanalysis' (2006)

structures and economic incentives, the quality of a government administration is influenced by cultural factors such as trust and social cooperation. This approach does not undermine the importance of formal law and institutions, but it highlights the relevance of understanding people's internal motivations and their perceptions, and how these shape attitudes towards institutions such as the government and the law.

According to Bo Rothstein, quality of government[169] is based on *how* government is exercised. In his book *The Quality of Government: Corruption, Social Trust and Inequality in International Perspective,*[170] Rothstein defines quality of government as the *impartiality* exercised in the output side of a political system. In his own words:

> When implementing laws and policies, government officials shall not take into consideration anything about the citizen/case that is not stipulated beforehand in the policy or the law[171].

According to the author, the output or exercise of public authority contrasts with the input or access to public authority insofar as the latter defines the way through which leaders and public officials are chosen - the electoral system or Supreme Court nominations, for example. Focusing solely on these procedures may not *per se* result in a good government as these inputs do not necessarily produce good outcomes for the people – i.e., research has shown

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[169] 'It should be obvious that as soon as one puts terms like "good" or "quality" into a definition, it is impossible to refrain from discussing the normative issues about what should count as "good" that have been raised in political philosophy. The same argument can be made for the concept of corruption that is usually defined as the "misuse" or "abuse" of public power for private gain. It goes without saying that one cannot understand what should count as "misuse" or "abuse" of a public position without referring to a normative standard for the proper role of the state and what type of moral standards citizens have the right to expect when public power is exercised' (Bo ROTHSTEIN, *The quality of government: Corruption, social trust, and inequality in international perspective* (University of Chicago Press 2011))

[170] Ibid

[171] Ibid

that voters tend to support candidates who are corrupt[172] or clientelist even if morally denouncing their actions.

The definition of quality of government developed by Rothstein fits well the case study of health care litigation in Brazil precisely because it focuses on the problem of *impartiality*. Going back to chapter 2 and the sociological backgrounds of Brazil, the patrimonial and personalist way through which power is distributed and exercise in country (otherwise known as clientelism) is the root of the inequalities. Since the colonial times, Brazil has been ruled by an elite that favoured itself through the manipulation of the law and public institutions. It has done so through the appointments of family and closed ones for public positions (nepotism), through the use of the legislative machinery to propose and enact legislation that benefited a particular interest group, by financing electoral campaigns with the capital of powerful economic elites, who would later 'get it back' via public contractual concessions, or through bribery and embezzlement. Even though the literature and data show that Brazilian institutions have grown stronger[173] and the rule of law more solid, it is undeniable that Brazil is still ruled by and for a political and economic elite.[174]

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[172] Catherine E. De VRIES and Hector SOLAZ, 'The Electoral Consequences of Corruption' (2017) 20 Annual Review of Political Science 391

[173] 'The post-1985 period, the federal bureaucracy was reshaped to emphasize universal procedures and merit-based recruitment. In 1988 a new Constitution was adopted that, in the words of two observers, "extended fairly rigid Weberian reforms, such as entrance only by examination and tenure for all civil servants," to the federal public administration (Heredia and Schneider, 2003: 11). In the mid-and-late1990s a major reform of public administration took place. While described by its chief architect as a post-Weberian managerial reform (Bresser Pereira, 2003: 90), it largely preserved and expanded the Weberian constitutional modifications of 1988 by, for example, regularly scheduling civil service exams that had formerly been irregular and ad hoc (Bresser Pereira, 2003: 103-104; see also Rezende, 2004). Melo 2002: 169) notes that in 1995, at the beginning of the presidency of Fernando Henrique Cardoso (1995–2002), the federal government announced the immediate hiring of 240 civil servants in areas such as budgeting, finance, and public policy in the name of greater efficiency. Rezende (2004: 89) shows that the reforms of the late 1990s were closely monitored and encouraged by international financial institutions. In 1999, for example, the International Monetary Fund applauded Brazilian efforts to reduce overall spending on public employees while at the same time making civil service salaries, especially at the top levels, commensurate with salaries in the private sector.' (PEREIRA, 'Is the Brazilian State "Patrimonial"?')

[174] According to the World Inequality Report produced by the World Inequality Lab, Brazil is ranked as one of the most unequal countries in the developing world, with the top 10% receiving over 55% of the total income in 2015, while the bottom 50% had just above 12% of the income share and the 40% in the middle, approximately 32% (https://wir2018.wid.world/files/download/wir2018-full-report-english.pdf).

Even though it is possible to affirm with a degree of confidence that Brazil is an extremely unequal country, the above made statement is a somehow simplified diagnostic of Brazil's quality of government. Impartiality, as other indicators that help to measure the quality of government or governance[175] explored in the wider literature, such as adherence to the rule of law, voice and accountability, political stability and the absence of violence, government effectiveness, regulatory quality and control of corruption,[176] are usually interdependent factors which are hard to isolate. Hence, most of the indexes that rank the quality of a country's governance is based on its populations' perceptions of several factors, such as impartiality, rule of law, corruption and violence. This is why it is so important to understand people's perceptions, and in the context of my particular case study litigants and judges' perceptions.

3.3 How do Brazilians evaluate the public health care system, SUS?

> The SUS is a wonderful system, I think that there is no other country with a better system. It is, in my opinion, an almost perfect system. It is not perfect because it is in Brazil. Because of the widespread corruption[177].

More often than not perceptions of trustworthiness, judgment of the quality of a public service, morality of officials and their competence do not necessarily reflect the facts. Arbitrating someone's trustworthiness is a difficult task even in personal relationships. In 'institutional trust', where the trusted object is non-personified, measuring trustworthiness is even trickier and almost never objective. Furthermore, as Onora O'Neill points out, the search

[175] According to the Worldwide Governance Indicators produced by the World Bank: "Governance consists of the traditions and institutions by which authority in a country is exercised. This includes the process by which governments are selected, monitored and replaced; the capacity of the government to effectively formulate and implement sound policies; and the respect of citizens and the state for the institutions that govern economic and social interactions among them." (Available at http://info.worldbank.org/governance)

[176] These are the six indicators taken into consideration by the World Bank in its research *Worlwide Governance Indicators* conducted over 200 countries and territories. Available at http://info.worldbank.org/governance/wgi/#reports.

[177] Interviewee 37 (2017) Interview with medical doctor from SUS in São Paulo (SP) [22/01/2017].

for transparency through thorough regulations can have the opposite effect on people's understanding (and trusting) of institutions:

> The perception that experts, professionals and institutions are now less trustworthy does not reflect clear evidence of increasing untrustworthy behaviour, but rather the fact that proliferating regulatory requirements define and detect more types of failure and receive more time and attention[178].

Health care is an extensively regulated sector, and one which impacts the lives of actors from various origins – i.e., citizens of all classes and regions, health-professionals, bureaucrats, pharmaceutical companies, politicians and the media. The quality of a health care system can be measured through objective factors. But the perception people build of it is much more affected by how they experience (or not) the system than of the objective parameters used by regulators to measure its quality.

For example, in order to evaluate a country's health care system, the Organisation for Economic Co-Operation and Development (OECD) uses several objective indicators, such as life expectancy at birth, main causes of mortality, infant health, population coverage for health care, out-of-pocket medical expenditure, hospital mortality rates, vaccinations, number of medical graduates, health workforce and health expenditure per capita and in relation to GDP[179]. These indicators can provide a good account to specific problems which might affect a particular area and combined, are also able to provide a bigger picture to a country's health care situation. Nevertheless, seldom the ordinary citizen, especially those with lower levels of education, will have access to those numbers.

[178] O'Neill, 'Linking trust to trustworthiness'

[179] For a detailed look into OECD's health indicators for 2017: OECD (2017), *Health at a Glance 2017: OECD Indicators*, OECD Publishing, Paris. *http://dx.doi.org/10.1787/health_glance-2017-en*

Another evaluating measure are the health care ranking reports, such as the ones developed by the Word Health Organisation (WHO), and Legatum Prosperity Index (LPI). According to the LPI's index for 2020[180], Brazil's health system ranked in 65/167 countries evaluated – in contrast to 2011, when it was ranked in 52/167. The WHO 2000 report ranked Brazil in 125 out of the 190 countries analysed[181]. Even though Brazil's low position in the indexes indicates a comparative low quality of its health care system, the WHO also reports important positive developments in the Brazilian Health Care System, such as the drastic reduction of health-related gaps through the implementation of policies for social inclusion; expansion of primary health care (PHC) coverage and increase of public health spending. These numbers corroborate an assessment of quality conducted with SUS users[182] and of health-professionals in 2020. Accordingly, a medical doctor who had experience as civil servant of the Secretary of Health of São Paulo, reflects:

> The SUS is a very modern system. [The problem is that Brazil is] a poor country and our health system is underfunded. But SUS has organised procedures, complex treatment protocols, (…) and an adequate hierarchy. We just have to work for it to be more efficient.[183]

Furthermore, according to research conducted in 2014 by a Brazilian private research institute, Data Popular[184], with 3,000 interviewees from fifty-three cities of all regions of the country, 91% of Brazilians thought that health care should be provided free of charge by the state. However, the same research indicated high levels of dissatisfaction with the quality of

[180] Legatum INSTITUTE, 'Legatum Prosperity Index' (*Legatum Institute*, 2021) <https://docs.prosperity.com/1516/3515/9792/Brazil_2021_Picountryprofile.pdf> accessed 05/11/2021

[181] World Health ORGANIZATION, *World Health Report* (Geneva, Switzerland, 2000)

[182] Research available at http://portal.cfm.org.br/images/PDF/datafolha_sus_cfm2018.pdf accessed on January 22nd, 2020.

[183] Interviewee 31 (2017) Interview with medical doctor and former civil servant of the Secretary of Health care in São Paulo (SP) [12/01/2017].

[184] Among the interviewees, 75% affirmed to be dependent of the public health system. Available in Portuguese at https://exame.abril.com.br/brasil/servicos-publicos-sao-mal-avaliados-aponta-pesquisa/

the public system provided - at the time, interviewees gave SUS a 3.73/10 score. Another qualitative study conducted by DataFolha[185] showed that the issue regarded as most pressing by users of the public health care system was the difficulty of getting an appointment with a specialist doctor (74%) followed by the difficulty of scheduling a surgery (68%). However, when the question referred to an issue foreign to the respondent's experience, such as the institutional reasons for explaining the low quality of SUS or what the focus of the policy should be, then answers tended to refer to question of politics. For example, when asked to number the priorities for the health care policy in their view, the number one response was fighting corruption within the health care system (26%), followed by reducing the waiting times for appointments, exams, and operations (18%) and, finally, monitoring the quality of services offered by SUS (13%).

The same discrepancy observed in the study mentioned above, in which the issues directly experience by respondents received specific responses, whilst issues not experienced by the respondents received generic ones, is also observed in relation to users and non-users of the SUS during my interviews. Moreover, when questioned about the quality of the health care system non-users had a worse perception of the public health care system in general – which confirms the quantitative research which indicates that non-users and non-exclusive users tend to have worst impressions of SUS in comparison to users' evaluation[186]. Furthermore, according to this same research by the CONASS (National Council for Health care Secretaries), the income levels is inversely proportional to the evaluations given by citizens, i.e., those with lower incomes better evaluate the SUS.

[185] Available at https://portal.cfm.org.br/images/PDF/datafolha_sus_cfm2018.pdf

[186] Conselho Nacional de Secretários de SAÚDE, *A saúde na opinião dos brasileiros* (Conass Brasília 2003)

These findings help shed light onto the opinion judges have of the public health care system insofar as judges tend not to have personal experiences using the SUS. The Brazilian Judiciary offers judges private insurance, who therefore tend to use the private health care system. Another aspect pointed out by interviewees is that judges lack the technical knowledge about the procedures involved in policy making in general, and specifically the technical knowledge involved in the policy decisions of health care. According to a private attorney, specialised in health care law:

> [O]ne major explanation for the [increase in successful health care] litigation is the judges' lack of knowledge about the public policy. Because judges' do not understand how the SUS and the Executive power really works, they presume that the bureaucrats are not able to resolve the issues administratively.[187]

A judge from São Paulo confirms such impression when saying that:

> There is a complete lack of knowledge from the judges' side [about the health care policy], which is a reflex of their lack of humility to try to understand how the health sector works. That happens because we believe that every public official is corruptible (…) just because they are part of the government.[188]

The way in which interviewees framed their criticism about the health care policy during interviews, often reflected their lack of technical knowledge about the policy making. Particularly in relation to judges, their evaluations about the quality of the system were mostly phrased in negative and generic stances – i.e., 'the system does not work'[189], or 'many public officials are corrupt'[190], or 'the policy maker is captured by private interests'[191]. Only in very exceptional cases did the interviewees present concrete data to back-up their claims - those

[187] Interview with private lawyer, specialist in health care litigation, in Santa Catarina on February 3rd, 2017.

[188] Interview with an appellate court judge in São Paulo on December 13th, 2016.

[189] Interviewee 17 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

[190] Interviewee 32 (2017) Interview with first-degree judge in Campinas (SP) [16/01/2017]

[191] Interviewee 14 (2016) Interview with first degree judge in (SP) [03/12/2016]

were interviewees that were directly involved in the policy making, like officials of the Executive power[192] or representatives of pharmaceutical industry and patients' associations. In some instances, prosecutors[193] and public defenders also demonstrated during the interviews a higher degree of technical knowledge about the system.

Particularly in the case of judges, even those of the Superior and Supreme Court, there was *no* single mention of concrete data about the overall quality of the health care system in Brazil. Interestingly, as it will be developed further in chapter 5, in most cases the judicial decisions do not use objective factors for granting drugs and treatments not covered by the health care policy. These arguments are confirmed by research conducted by Insper[194] which investigated the pattern of legal reasoning by judges and justices to justify decisions granting drugs and treatments. The research found out, for example, that only 3.88% of the decisions analysed mentioned ANVISA, 0.22% mentioned the CONITEC and 3% mentioned the RENAME[195]. Another interesting finding of this research was that most decisions that mentioned ANVISA and CONITEC denied totally or partially the claim, which could indicate that understanding about the policy system reduced the chances of granting the claims. As said, these points will be further explored in chapter 5, which discusses the disconnection between

[192] For example, an official of the São Paulo State Government affirmed that: 25% of patients today, in Brazil, have health care insurance. These 25% who have health insurance have access to 55% of the overall health resources in the country. That is, the remaining 75% have to cope with 45% of health budget. (…) The per capita investment in the population depending on the SUS for health is much lower than the per capita investment in the population that has access to private medicine and health insurance (interview conducted in São Paulo on January 14th, 2017).

[193] 'Out of the 600 hospitals accredited to SUS in São Paulo, only 150 would really be necessary and economic (rational); this means that 450 hospitals are uneconomic. It is a hospital-centred fetish that is draining money out of the SUS's basic-care budget' (Interviewee 30 (2017) Interview with second-degree prosecutor in São Paulo (SP) [12/01/2017]).

[194] DE AZEVEDO, ABUJAMRA and ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução*

[195] RENAME is the list of medications supplied by the national public health care system.

the motivations referred to by judges during interviews and the legal reasoning of published judicial decisions[196].

Even though perceptions do not necessarily mirror facts/reality, they do indicate how people grasp and internalise situations, and how these perceptions inform the decisions they make later. Thus, the importance of understanding people's perceptions of a given phenomenon is so that we have a broader comprehension of what drives them to their decisions and what factors influence their behaviours.

The common thread amongst users and non-users of the public health care system, litigants, and public officials (including judges), was a generally constructed negative perception of a malfunctioning state, where lack of political will, bad bureaucracy, poor governance and corruption resulted in the problems experienced by them or others, including limited access to drugs and health care devices.

3.4 Perceptions of Corruption amongst Brazilians: a fuel for social distrust

'They don't care about the people'[197] said one interviewee who had to file a legal claim in order to get access to a special non-allergenic milk for her baby, when asked what she thought about the quality of the public health care system of Rio de Janeiro.

According to Transparency International, corruption is 'the abuse of entrusted power for private gain'[198]. This concept is in line with the notion of expectations and confidence in the officials' competence to exercise his/her legal duties. Distrust in such cases then refers to

[196] On the theme of non-legal factors influencing judicial decision-making, see Diana RICHARDS, 'Experience in Sentencing-New Empirical Insights on What Judges Think They Do in Court' (2015) Available at SSRN 2613060 and Charles GEYH, *What's Law Got to Do with It?: What Judges Do, why They Do It, and What's at Stake* (Stanford University Press 2011)

[197] Interviewee 19 (2016) Interview with litigant in Nova Iguaçu (RJ) [08/12/2016].

[198] Anita JAIN, Samiran NUNDY and Kamran ABBASI, *Corruption: medicine's dirty open secret* (British Medical Journal Publishing Group 2014)

the rupture of citizens' expectation that those in charge of public institutions will deliver – or do their best to deliver – the public services, impartially. Corruption breaks impartiality and impacts the quality of public services, creating institutional distrust.

Transparency International's 2020 rank on perception of corruption in Brazil[199], ranks the country in 94 out of 180 nations assessed in the Transparency International Corruption Perceptions Index. Corruption imposes the most significant obstacle for doing business in the country, according to a 2009 World Bank Enterprises Survey. And, not surprisingly, corruption scandals have undermined the trust in both private and public institutions (World Economic Forum, 2015/2016 report). Institutional (dis)trust is fed by perceptions of corruption. And, in an environment of perceived corruption, people coordinate less and are thus more prone to engage in corruption, even if petty, reinforcing the cycle of distrust and corruption which feeds from one-another.[200]

Taking into consideration Bo Rothstein's concept of *quality of government,* discussed above, corruption is a form of disrupting the government's quality insofar as it occurs when a public officer violates the principle of impartiality to achieve a private gain.[201] However, corruption is a very complex problem which lacks a uniform empirical understanding, given its variations from country to country. Some societies and citizens of a country may define a particular action as corrupt while others do not. In Brazil, for example, even though corruption is morally condemned by the vast majority of the population, quantitative research has shown

[199] Transparency INTERNATIONAL, *Corruption Perceptions Index*, 2020)

[200] Timothy J POWER and Júlio GONZÁLEZ, 'Cultura política, capital social e percepções sobre corrupção: uma investigação quantitativa em nível mundial' (2003) Revista de Sociologia e Política 51

[201] ROTHSTEIN, *The quality of government: Corruption, social trust, and inequality in international perspective*

that the Brazilian citizen is prone to engaging in petty corruption or justifying corrupt actions due to necessity.[202]

Furthermore, levels of corruption are hard to be measured objectively precisely because of the nature of corrupt behaviours. Under that framework, there is a fairly cohesive agreement in the literature that corruption should be analysed empirically, taking into consideration the political and cultural particularities of each society. This is one underlying reason for the critiques addressed to international ranks of corruption such as the Corruption Perception Index (CPI) conducted by Transparency International, which measures the perception of corruption citizens, analysts and public officials have of a country. The CPI indicates, however, the reputational paradigm of a country's perceived corruption. It is one of the tools which can be considered to build the bigger picture and understand the factors underlying social behaviour and the consequences of it.

Regardless of the difficulty of conceptualising and measuring it, corruption was a topic brought up by 53 interviewees during the interviews I conducted in Brazil. In one way or another, corruption was an issue associated with politics and the health care policy by almost *all* interviewees, and thus a significant driver for people's behaviour. Hence it is imperative to dedicate some time to exploring how perceptions of corruption impact – directly or indirectly – people's decision to start legal action, or judges' decision to grant claims. It must be stressed that, in the same way as the discussion of the *quality of the Brazilian government*, my goal in this section is not to judge or measure objective rates of corruption in Brazil, but to focus on the perceptions of corruption and how those influence litigant's decision to start action and judges' decisions to grant claims.

[202] Fernando FILGUEIRAS, 'A tolerância à corrupção no Brasil: uma antinomia entre normas morais e prática social' (2009) 15 Opinião Pública 386;

As Lopes and Santos explain[203], particularistic levels of trust, known as bonding, can constitute a negative social capital which correlates with high corruption levels. In a corruption scheme, the participants need to establish high levels of interpersonal trust for there to be coordination. Such levels of particularistic trust are generally identified in the Brazilian society, which tends to have high levels of trust in family and close friends, but low levels of generalised and institutional trust. This same pattern, called *amoral familism* by Edward Banfield[204], is identified in Italy, where citizens are unable to act together for the sake of the public good, refusing to coordinate with anyone who escapes the nuclear family. Conversely, in Italy, as in Brazil, there are high level of particularised trust within small circles of family and kinship[205]. This theme will be further explored in Chapter 6, when analysing the behaviour of litigants in the health care litigation phenomenon in Brazil, who display a utilitarian relationship with the public sector and lack the vision of the bigger picture or concern with the public good.

As explored in Chapter 2, Faoro[206] explains how Brazilians developed a confusing relationship with a public and private sphere, having as a consequence constructed a perception of the government, politicians and public officials historically as an elite that will do anything to remain and retain power. This perception is in a way confirmed, and fostered, by the high number of corruption scandals involving politics in Brazil, throughout all governments since the start of the Republic[207]. During the years I conducted the interviews in Brazil, the Operação Lava Jato (Car-Wash operation) was in full speed. The daily reports of warrants and arrests

[203] José Atilano Pena LÓPEZ and José Manuel Sánchez SANTOS, 'Does corruption have social roots? The role of culture and social capital' (2014) 122 Journal of Business Ethics 697

[204] Edward C BANFIELD, 'The moral basis of a backward society' (1967)

[205] Ken NEWTON and Pippa NORRIS, 'Confidence in public institutions' (2000) Disaffected democracies What's troubling the trilateral countries

[206] FAORO, *Os donos do poder-formação do patronato político brasileiro*

[207] Erica Anita Baptista SILVA, 'Corrupção e opinião pública: o escândalo da Lava Jato no governo Dilma Rousseff' (2017) and Túlio Gonçalves GOMES and Cintia Rodrigues de Oliveira MEDEIROS, 'Construindo e desconstruindo escândalos de corrupção: a operação Lava-Jato nas interpretações da Veja e Carta Capital' (2019) 26 Organizações & Sociedade 457

were the centre of Brazilian news, nationally and internationally[208]. The operation resulted, so far, in more than 2,000 years of jail time and prosecuted 426 persons, including the former President Luís Inácio Lula da Silva.

On the one hand, Operation Lava-Jato, as other major corruption operations conducted by the Federal Police and the Prosecutors Office, can signal to an advancement in the accountability mechanisms and the rule of law in Brazil. The imprisonment of powerful politicians and businessmen like Marcelo Odebrecht were interpreted as an indicator that the political and economic elite, historically known to enjoy impunity, were no longer untouchable. On the other hand, Lava-Jato was part of a *perfect storm* that opened space to an increased *law and order discourse*[209], which ultimately resulted in the election of the right-wing President Jair Bolsonaro in 2018. Additionally, the daily depiction of billionaire corruption schemes in the Brazilian media, accompanied by the worst economic recession in the history of the country, created an echo-chamber, resulting in an increased perception of generalised corruption and a consequent institutional distrust crisis.[210]

Corruption is also part of the Brazilians day-to-day life, and it is, to a degree, tolerated[211]. This familiarity with corruption and illegality cases also feeds Brazilian's constructed idea of a generalised corruption that takes over society and institutions. That does not mean that corruption is morally accepted in Brazil. On the contrary: research shows that

[208] Operation Carwash is a criminal investigation that began in 2014, unveiling the biggest corruption scheme of the history of the country involving the oil State company, Petrobras, politicians from all the major political parties and the elite of private sector.

[209] Wendy HUNTER and Timothy J POWER, 'Bolsonaro and Brazil's Illiberal Backlash' (2019) 30 Journal of Democracy 68

[210] Peter R KINGSTONE and Timothy J POWER, 'A Fourth Decade of Brazilian Democracy' (2017)

[211] FILGUEIRAS, 'A tolerância à corrupção no Brasil: uma antinomia entre normas morais e prática social'

the great majority of Brazilians reject corruption as an idea and do not consider themselves a corrupt[212].

The rejection of corruption but wide-spread presence of corruption-like actions presents an antinomy of a society in which the moral values contradict the social practice[213]. This is another example of the constant tension and duality present in the Brazilian social structure, explained in chapter 2. The social construction of the idea that the Brazilian political sphere is taken by a wide-spread corrupt elite, increases the generalised distrust and alienation from the political processes. A justice from the Supreme Court, in one of the interviews[214], theorises that the rejection of politics due to its association to corruption, has led young legal academics and professionals who had a drive for social causes, to fulfil their latent wish for impact through careers in the Judiciary and the Public Prosecutors' Office. This, according to him, partially explains several generations of activist judges and prosecutors who are prone to act on behalf of the citizens, and against the [perceived corrupt] state.

In a scenario were judges see themselves having to decide to grant drugs, treatments or medical devices not covered by the health care public policy, culturally constructed perceptions of a wide-spread corruption in the state bureaucracy fuel a lack of deference for the administration's authority.

3.5 Separation of Powers and Judicial Deference to the Public Health care System

> [F]or a moment, just for a moment, I really tried to observe the separation [of powers], because I really wanted to believe the State would be able to walk by itself[215]

[212] Ibid

[213] Ibid

[214] Interviewee 49 (2017) Interview with Supreme Court judge in Brasília (DF) [07/02/2017].

[215] Interviewee 16 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016].

As a constitutional doctrine, the separation of powers was developed in the 18th century to prevent tyranny and the abuse of state power[216]. However, the doctrine also acknowledges that the state functions – i.e., executive, udicial and legislative – cannot be 'hermetically sealed from each other'[217]. There is a need for the existence of checks and balances which guarantee the mutual supervision, transparency, and accountability amongst powers. This very delicate equilibrium between a state power's independence and the appropriate supervision from other bodies of state has the aim of guaranteeing that institutions do not suffer pressure or excessive influence from the other powers, while impeding the abuse of power and the invasion of another institution's attribution.[218]

In the case of the Judiciary this control is done by giving courts the power to self-regulate, control their finances, impose administrative sanctions on judges, and not be subject to salary reduction or arbitrary re-positioning of jurisdiction. In the case of Brazil, the Judiciary upholds high levels of independence both institutionally – independence from the interference of other powers – and internally – independence of judges from all levels to adjudicate without the interference of higher courts. Furthermore, the process of selection for new judges (*concursos*) and administrative procedures to investigate and punish judicial misconduct, are also conducted internally by the state or federal court in which the judge serves.

Judicial review

Judicial review in Brazil gives the Judiciary a wide margin to examine and reform administrative acts in relation to legality and constitutionality. In theory, the merits of an administrative decision should not be revised through judicial review, as they form part of the

[216] Charles DE MONTESQUIEU, *Montesquieu: The spirit of the laws* (Cambridge University Press 1989)

[217] Aileen KAVANAGH, 'The constitutional separation of powers' (2016) Philosophical Foundations of Constitutional Law

[218] Ibid

discretionary power of the administration[219]. However, the praxis in Brazilian courts is much less clear-cut. Whilst in some areas the Judiciary has shown great deference to the administrative authority, such as in antitrust[220], in others, courts have been considerably more activist, like the cases of health care litigation discussed in this study.

So how are these judicial decisions lawful? Because judges argue that by granting access to health care via individual litigation, they are not performing judicial review *per se*, but enforcing a constitutional right to health care (article 196) which must then be fulfilled by the administration. To be able to design the judicial decision under such premises, judges refer to constitutional law, making use of vague constitutional principles (which some argue are programmatic) to enforce a positive outcome. This will be further analysed in chapter 5 when I talk about how judges *use* the formal law to achieve their desired results. In this chapter, my focus is to show how the judicial activism in health care litigation arises from judge's distrust in the administration, which in its turn fuels their disposition to grant access to health care despite the public policy in place.

The system of judicial review in Brazil is hybrid, allowing for abstract, concentrated control – typical of common law countries such as the United States, and concrete, diffuse control – observable in civil law countries such as Germany and Italy. In the first abstract model, the control of constitutionality can only be exercised outside of a concrete case (in abstract) and by the Supreme or Constitutional Court (which holds the sole power of abstract judicial review). In the second, concrete model, the judicial review can be done during the

[219] There is no explicit provision in the Brazilian law forbidding judges to reform the merits of administrative acts, however, the Supreme Court has decided that, in accordance to the principle of separation of power, judicial review must be limited to the control of legality and abuse of power (i.e. *ARE 779.212/PR* Luís Roberto Barroso (Braziian Supreme Court (STF))

[220] For a quantitative analysis of judicial deference to different agencies in Brazil, see: Juliano Souza de Albuquerque MARANHÃO, 'A revisão judicial de decisões de agências regulatórias: jurisdição exclusiva' (2016) O Judiciário e o Estado Regulador Brasileiro São Paulo: FGV Direito SP 26)

adjudication of a concrete lawsuit, and by any judge (diffuse control). This means that the constitutionality of laws and administrative acts taken by all levels of the State – federal, state or municipal - can be challenged before any judge in Brazil during the course of a litigation, as well as through special actions at the Supreme Court[221].

This ample form of judicial review confers on all 17,000 Brazilian judges the power to review an administrative act and control its constitutionality. In this system, the limits of where the Judiciary is not to interfere – non-justiciable issues – can get blurry, depending on the judges' will to defer to the administrative expertise as much or as little as (s)he pleases – using the constitutional law as a legal resource to enable such interference.

> That [judicial] deference [to administrative decisions] in Brazil does not exist. We see this clearly. The judge distrusts the State, as if the presumption of legitimacy for the administrative acts was reversed. It is not a presumption of legitimacy; it is a presumption of illegitimacy. Which is absurd[222].

As explained in Chapter 2, Brazil underwent several waves of administrative reform seeking to modernise the country's bureaucracy. One of the main goals of making the Brazilian State machine more efficient was attracting foreign investments. For that to happen, the country underwent a wave of privatisations, including de-statisation of public companies in the 90s. The model of a high interventionist state was then substituted by a regulatory state, where private companies could operate more freely with an indirect oversight of regulatory agencies[223]. However, several privatisation agreements were contested in courts, which gave a rise to the discussion of judicial deference to administrative expertise in Brazil. Whilst in the

[221] Keith S ROSENN, 'Judicial review in Brazil: Developments under the 1998 Constitution' (2000) 7 Sw JL & Trade Am 291

[222] Interview with Superior Court Justice in Brasília on February 28th, 2016.

[223] Eduardo JORDÃO and Renato Toledo Cabral JUNIOR, 'A TEORIA DA DEFERÊNCIA E A PRÁTICA JUDICIAL: UM ESTUDO EMPÍRICO SOBRE O CONTROLE DO TJ RJ À AGENERSA' (2018) 4 REI-REVISTA ESTUDOS INSTITUCIONAIS 537

United States the standard for judicial review was established in the Chevron case in 1984[224], and in the UK by the ultra vires doctrine[225], there were no legal parameters defined in Brazil by statutes or a binding case law. In other words, although the Supreme Court has decided on various occasions that the judicial review in Brazil is limited to the analysis of legality, those decisions referred to specific themes of administrative law, such as the principle of legality, morality, publicity and efficiency, and where not conferred binding powers to be applied more generally to judicial review in other areas (such as health care). Thus, there are no clear parameters in Brazilian law of what the limits of judicial control of administrative acts are.

This *lacunae* in the interpretation of the scope of *judicial review* in Brazil, added to the high number of claims filed against the state, and to the use of abstract principles of constitutional law to invalidate administrative decisions, generated a sea of inconsistent judgements and different judicial interpretations as to how and to what extent the Judiciary in Brazil should or could interfere in the administrative discretion.

> It is the Judiciary itself that induces the judicialisation and this is curious because we are encouraged to work on this idea of reducing legal claims, of avoiding judicialisation, but what we often perceive is that the judge is not worried about it. It is a concern here at ANVISA or the public attorney's office (…). But these judicial decisions actually foster litigation, incentivise people to file more and more lawsuits. You start to think... How much is the aspiration for litigation reduction embraced by the Judiciary and not just a discourse?[226]

Given this lack of a general rule, the analysis of the Brazilian courts' position about judicial review has to be done on a case-by-case basis – i.e., thematically, according to the particular nature of the topic discussed such as aviation, energy or health care. When doing so it is easy to observe a lack of consistency in the application of the separation of powers doctrine

[224] Chevron U.S.A., Inc. v. NRDC, 467 U.S. 837 (1984)

[225] Paul CRAIG, 'Ultra vires and the foundations of judicial review' (1998) 57 The Cambridge Law Journal 63

[226] Interview with ANVISA's public attorney in Brasília on November 18th, 2016.

and the deference theory, dependent on the theme involved in the claim. In the case of health care, as it will be further analysed in this section, the widespread judicial interpretation is that cases which discuss the access to drugs or treatments not approved by the ANVISA or not included in the public health care system defined by the CONITEC, do not violate the separation of powers doctrine.

Furthermore, deference demands trust. Trust that the institutions will conduct their jobs according to the legal definitions and standards, competently. In a country where trust amongst citizens and the institutions has been corroded by a history of colonialism and a nepotistic political elite, deference can easily be cast aside. One judge, for example, when asked about the need for deference to the health administrative authority, replied: 'it is a matter of life and death, I don't care about the ANVISA'[227] . Meanwhile, a civil servant of ANVISA comments:

> I even have an internal conflict in relation to [the restraint on judicial review] because, obviously, my position (…) as a public lawyer would be to argue that judges should not grant drugs not approved by the policy. But personally, I think that in the face of the inefficiency and the general disregard for the [legal] rules, I am in favour [of judges granting drugs and treatments not approved by ANVISA][228].

The distrust in public institutions and politics in general is evidently an important factor not only in judges' propensity to decide health care claims against the state favourably to the patient, but also more broadly in the inter-institutional relationship established between powers in Brazil. Although not expressly admitting the political nature of their judgments, Brazilian judges and courts make a clear political choice when choosing to grant drugs and treatments not covered by the policy, disregarding the separation of powers. The legal argument, however,

[227] Interviewee 21 (2016) Interview with public defender in Rio de Janeiro (RJ) [09/12/2016].

[228] Interviewee 54 (2017) Interview with public lawyer for ANVISA in Brasília (DF) [07/06/2017]

expressly denies such disregard for the constitutional doctrine. For example, in a decision of the Superior Court of Justice:

> Social rights cannot be conditioned to the goodwill of the Administration, and it is of utmost importance that the Judiciary acts as the controlling body of administrative activity. It would be a distortion to think that the principle of separation of powers, originally conceived with the scope of guaranteeing fundamental rights, could be used precisely as an obstacle to the realisation of social rights, which are equally relevant.
> 3. In the case of an essential right, included in the concept of an existential minimum, there will be *no legal obstacle* for the Judiciary to establish the inclusion of a certain public policy in the budgetary plans of the political entity, especially when there is no objective evidence of the economic and financial incapacity of the State.[229]

When asked about the implications of the separation of powers in health care litigation, a public attorney affirmed the state's defence 'gave up' arguing that the decisions to grant drugs and treatments not approved by the public policy conflicted with the separation of powers.

> We had to change the strategy (…). After the decision of Celso de Mello, judges started repeating like a mantra that between the fundamental right to life and the states bureaucracy, they choose the former[230].

The above-mentioned decision was given in 2004 by the Supreme Court Justice Celso de Mello, monocratically – individually by the rapporteur, without submitting to the collegiate of judges. According to it:

> [I]n principle, the Judiciary Branch should not intervene in a sphere reserved for another branch, to replace it in judgments of convenience and opportunity, wanting to control the legislative options for [budget] organization and provision, unless, exceptionally, when there is an evident and arbitrary violation, by the legislator, of the constitutional mandate. However, it seems to us ever so necessary to revise the old dogma of the Separation of Powers in relation to the control of public spending and the provision of basic services in the Welfare State, since the Legislative and Executive Powers in Brazil have been unable to guarantee a rational fulfilment of the respective constitutional precepts[231].

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[229] REsp 1488639/SE, Herman Benjamin (2014 (Brazilian Superior Court of Justice)

[230] Interviewee 28 (2017) Interview with public attorney for the Secretary of Health in São Paulo (SP) [12/01/2017].

[231] ADPF 45 MC/DF, Celso de Mello (2004) (Brazilian Supreme Court)

The fact that the doctrine of separation of powers in the context of health care litigation in Brazil ceased to be a debated legal issue shows how the Judiciary has carved itself a role in the power of defining the health care policy. According to a Supreme Court Justice:

> To the extent that politics deteriorate, the coordination of political institutions decreases, the Judiciary expands. I mean, I do things, the Supreme Court does things that (…) maybe we should not do"[232].

The inter-institutional relationship resultant of this widespread distrust increases the distance between powers, producing institutional islands that do not communicate or respect one another. It is worth noticing that the disregard for the Executive's authority and expertise by the Judiciary is not a phenomenon restricted to health care cases. For example, in 2010 the Supreme Court ordered the state of Rio Grande do Sul to refurbish a prison establishment, setting aside the argument of infringement of the separation of powers given the higher relevance of the individual right to dignity breached in the case[233]. The same happens to pensions, as a public attorney reflects: 'when judges grant public pensions outside the pension policy, they are also infringing the separation of powers. Making a parallel, the same judicial empowerment based on constitutional principles happens in health care and public pensions'[234].

Interestingly, the interviews with judges confirm the idea that the institutional island increases the distrust amongst institutions, reducing the deference. Judges who had contact with civil servants from the Executive, either CONITEC or ANVISA, who attended

[232] Interviewee 1 (2016) Interview with a Supreme Court judge in Brasília (DF) [16/11/2016].

[233] RE 592581/RS, Ricardo Lewandowski (2015) (Brazilian Supreme Court)

[234] Interview with Public Attorney for the state of São Paulo on January 22nd, 2017.

conferences or classes about the policy making in SUS, showed more deference to the administrative authority and were less prone to deciding in favour of litigants. According to a public defender from Santa Catarina:

> Most judges are not specialised in health law. In law school, we do not have contact with sanitary law. However, here in Florianópolis there are health committees that meet once a month. So, the judges who take part in the committee, they end up listening about the secretary of health's problems, they become aware. They still want to help people but they understand that it is not possible to give everything to everyone, that the blanket is short. Those who do not have this contact [with the health authority], do not have an understanding of the public system as a whole, think that judicialisation is the best way[235].

Increasing transparency and building this bridge between the Executive and the Judiciary can not only reduce successful individual claims, but also open an avenue for more efficient solutions that focus on the collective. This requires, however, dealing with the Brazilian individualistic relationship with the public sphere, which is analysed in Chapter 6.

The National Justice Council and the Executive have, since 2009, increased initiatives to approximate the two powers via health care fora. However, to curb litigation, there had to be a shift in the legal interpretation as well. That happened partially in 2020, when the Supreme Court decided two paradigmatic cases debated between 2016 and 2019. One related to the judicialisation of drugs and treatments not approved by the health and safety agency, ANVISA. The second referred to litigations seeking high-cost drugs and treatments, approved by ANVISA but not included in the public policy, RENAME, by the Health Ministry's special committee, CONITEC. Led by the rapporteur Justice Marco Aurélio Mello, the Supreme Court changed the two decades long interpretation that such decisions did not breach the separation of powers. According to the consenting vote of Justice Luís Roberto Barroso:

> The Judiciary is overriding the performance of the competent bodies, replacing a technical choice (legitimised by the expertise of the commission and by the adopted

[235] Interview with public defender from Santa Catarina in Florianópolis on February 3rd, 2017.

> procedure) and unduly interfering in the public administration, in disrespect to the administration reserved competence and the separation of powers. In these situations, the Judiciary does not have the institutional capacity and knowledge necessary to fully assess the complex technical issues involved in deciding whether to incorporate drugs (e.g., to perform the cost-effectiveness analysis required by law)[236]

It is worth mentioning that the abovementioned decisions are extremely recent and albeit essential to curb the raise of successful health care claims against the state in Brazil, still do not pose a general interpretation of limits to judicial review in Brazil. It is yet to be seen how these decisions will be applied in lower courts and if the same rationale will be used to restrain the judicial activism in other areas, such as education and pensions, for example.

To conclude, in this section I analysed external factors such as the distrust in a perceived low-quality government in Brazil, lack of deference for the authority of the Executive, such as CONITEC and ANVISA, and disregard for the separation of powers as influencing the decision of judges to grant drugs and treatments not included in the health care public policy.

In light of such a distrusted government, judges have to *find a way around* the public policy in order to fix situations of perceived injustice. This *jeitinho* around the distrusted political system through law is what I analyse in the next section.

3.6 Granting health care through litigation: an institutional *jeitinho* around a distrusted health care policy in Brazil

'The State simply does not meet its minimum obligations, the most basic ones.' Answered a first-degree judge from the state of São Paulo[237] when asked 'why did health care

[236] RE 566471/RN, Rel. Marco Aurélio Mello (2020), Voto Vista Min. Luís Roberto Barroso

[237] Interviewee 11 (2016) Interview with first degree judge in Araraquara (SP) [23/11/2016]

litigation reach this magnitude in Brazil?'. Another interviewee, the president of a patients' association for rare diseases was blunter when answering the same question:

> It is very hard talking about this. Do you want the truth, the naked truth? [Health care litigation has reached this point] because of corruption. It's as simple as that".[238]

As presented throughout this chapter, the belief that the Brazilian government is deficient at its various levels was present in one way or another amongst almost *all* of the interviews I conducted in Brazil with key actors involved in health care litigation. From public officials to citizens, lawyers to members of the organised civil society, every single interviewee expressed, in some way, their *perception* of a *low quality* the Brazilian administration[239].

By linking the sociological background outlined in Chapter 2 and the empirical data presented in this Chapter, I suggest that the disposition of judges to grant health care claims and litigants use of the system to access drugs and treatments not provided by the system can be understood as an expression of the *jeitinho brasileiro.*

Moreover, by manoeuvring the constitutional law in the individual case, as a means to offer the individual litigants the drugs and treatments not covered by the public health care system can be framed as a *jeitinho,* a quick fix to solve, a perceived systemic problem of the public health care – which in theory[240] should be solved by the public health care policymaker. One first-degree judge reflects about how the Judiciary gets around the State's omission:

> [Judicialisation of politics] is not just about health care. It is in all areas; judicialisation has taken a major proportion [in Brazil]. (…) The first factor [behind this] is the State

[238] Interviewee 10 (2016) Interview representative of a patient's association in São Paulo (SP) [23/11/2016].

[239] ROTHSTEIN, *The quality of government: Corruption, social trust, and inequality in international perspective*

[240] For more on the power of regulatory agencies to decide policy issues independently: Saskia LAVRIJSSEN and Maartje DE VISSER, 'Independent administrative authorities and the standard of judicial review' (2006) 2 Utrecht L Rev 111; Martino MAGGETTI, *Regulation in practice: The de facto independence of regulatory agencies* (ECPR press 2012); Fabrizio GILARDI and Martino MAGGETTI, '14 The independence of regulatory authorities' (2011) 201 Handbook on the Politics of Regulation

> administration's omission. (…) The public administration is absented in several sectors (…) and the society has discovered that the Judiciary can be its strong arm. The Judiciary has embraced this cause. I think that even unduly… So much is said about judicial activism, which is a pejorative expression today – but it should not be. So why is the Judiciary advancing in the sphere of administration? Why are people, coming to [the Judiciary] to seek solution for public services? [Because] there is more and more tax burden and less and less State. So, people's indignation ends in lawsuits, in search of the strong arm of the State, which is the Judiciary. The Judiciary embraces their cause. The Judiciary does not omit itself. (…) Sometimes I even joke that the judge should leave the court and go to the city hall. (…) Also, the Judiciary is in a very comfortable position because it takes into consideration the fundamental right to health care, but it is not the one that has to manage the state budget. So, the big conflict today is this, of this judicial activism versus public budget. Which is admittedly insufficient for all the public services. [241]

The litigation *jeitinho* can be perceived beyond the actions of judges and litigants. A public attorney from São Paulo suggests that it is also a way that the Executive and Legislature found to not have to make the tragic choices[242] that the health care policymaking demands.

> The judicialisation brought, in the last decade, a diagnosis, which is literally rotting or rusting the public policy machine, competing with the rest of the allocative priorities of the State. So, instead of generating a virtuous circle, [health care litigation] generates a vicious circle where the Executive, childishly, delegates the tragic choices, the complex choices to the Judiciary. There is not only a judicialisation of politics but of the administrative role itself. The administrator prefers to leave the decision to the Judiciary because then (s)he does not have to start a procurement process. (S)he can buy directly and circumvent the whole cycle. (…) It is cheaper to answer the lawsuits, even if they are ever more expensive than to universalise the solution to the whole system. The government says that it costs 7 billion reais to meet the legal decision, but it is still cheaper than, for example, actually investing in primary, preventive care to relieve the hospital care[243].

[241] Interviewee 32 (2017) Interview with first-degree judge in Campinas (SP) [16/01/2017].

[242] 'A "tragic choice" is one involving life and death (at least probabilistically) or-less centrally- other vital personal goods such as child- bearing, where alternative technically feasible policies will have the effect (whether or not they have the intention) of distributing these goods and bads (or the probability of incurring them) in different amounts and/or in different ways among individual recipients' (Brian BARRY, *Tragic choices* (University of Chicago Press 1984) 304)

[243] Interviewee 28 (2017) Interview with public attorney for the Secretary of Health in São Paulo (SP) [12/01/2017].

With reference to the three dimensions of *jeitinho* explained in chapter 2, the use of judicial decisions in individual claims as a systematic form of accessing drugs, medical devices and treatments not covered by the public health care system, can be understood as both an exercise of the flexibility/creativity of Brazilians, and/or as a rebellious practice, a dodge. It is a form of creativity insofar as it is used with the intention to escape the perceived constrains of the system – a perceived bureaucratic, corrupt political environment - to solve a concrete problem – the need for a medicine or treatment. But it is also a rebellious movement, a dodge of judges who, conscious of the negative implication of health care litigation, still use their power and the law to grant individual requests. For example, a judge from the appellate court of São Paulo says that:

> This is a matter of public policy, […] and thinking about it with a cool head, the Judiciary should not interfere; in theory, it would not have to meddle in this matter. But, unfortunately, [these litigations] involve the fulfilment of a social right. So, I have no way to guarantee this right without interfering with the policy. […] Judges end up harming more than helping, but I don't see a way out[244]

This *dodging* angle also helps shed a light onto the aspects of judicial decision that escape constitutional rules such as the separation of powers and deference to administration expertise (section 3.6 below) and impartiality (chapter 4). Another way to observe the *rebellious* dimension of judge's behaviour is to compare the personal motivations provided by judges during interviews to justify their decision of granting the claims vis a vis the formal legal justification used in their written judgements. This is further analysed in chapter 5, which examines how the judges manoeuvre the constitutional law to justify a decision taken in hindsight – which some of them confirm doing in the interviews. Even if driven by a distrust in the Executive and a personal empowerment, in their legal decisions, judges hide the personal and political motivations under the veil of constitutional discourse – a *jeitinho* with the law.

[244] Interviewee 24 (2016) Interview with appellate judge in São Paulo (SP) [14/12/2016].

Another expression of the *jeitinho* can also be observed in the resistance judges show to collectivise repetitive individual health care claims. I will also discuss this issue in chapter 5 as an expression of how judges prefer to use the judicial process in a way in which they can exercise their own control, instead of starting an aggregating procedure that would inevitably send the cases to a higher instance of the judicial system, and thus take it out of their jurisdiction. Moreover, although existing, collective litigation are much rarer in Brazilian health care litigation. Some argue that by litigating individually, both litigants and judges "benefit" from not collectivising the claims, even if that meant more rational decisions.

It is important to remember that, as Da Matta[245] points out, the *jeitinho* must not be simply understood as a wrong or immoral behaviour. Beyond the tradition "cut the queue" element, the dodge, *jeitinho* is also an unorthodox manner of navigating rough institutional waters. A bending of formal procedures to correct imbalances and providing compensation for unjust scenarios. In the case of health care litigation, some judges and other actors, such as public defenders and prosecutors, believe that judicial decisions are an effective way to correct the current scenario in Brazil, where millions of citizens are denied access to a quality health care whilst a few others - like judges[246] themselves - have access to one of the best private health care systems in Latin America – even if knowingly disrupting the public budget, incentivising the use of the judicial system by economic powers and widening inequalities by cutting the queue to those who can access the legal system.

[245] DA MATTA, *Carnivals, rogues, and heroes: An interpretation of the Brazilian dilemma*

[246] The fact that judges have, through the public office social security, access to one of the best private health care insurances in the country means that they do not need to use the SUS. Judges, like the economic elite, can afford to pay private doctors and hospitals, which are known to be ranked amongst the best in the world. This puts judges, the ones ruling on cases, in a very different position to those requesting the drugs or medical care. This generates a sense of injustice which judges tend to think they need to correct, because they can. This will be address more carefully on chapter 5, when talking about empowerment, emotions and judicial activism.

In this chapter I focused my attention on judges, but the *jeitinho* can be attributed to all actors involved in the health care litigation. The reason for separating the analysis of judges from the one about litigants relates to the degree with which these interviewees linked their perception of a low quality of government to their decisions to start and grant health care litigation. Generally speaking, when I asked the so-called elite actors - judges, lawyers, health care professionals and other public officials in general, such as ANVISA and CONITEC agents - what were, in their opinion, the causes for the rise of successful lawsuits against the state, the majority of respondents explained the phenomenon drawing a direct reference to the low quality of health care services provided by the Brazilian state:

> If the [public] money is going to politicians' pockets, then we should at least pay the litigants' medication. That is the logic behind [my decision]. We [judges] try to use a few legal justifications in the decision, but the logic underneath it is that[247].

As it was probably expected, litigants did not establish such a direct causal link between the perceived low quality of government and their decision to start legal action against the public health care system. As I further analyse in chapter 6, their decisions were based on calculable factors, such as costs of litigation and the chances of getting the drug or treatment needed. That is not to say that factors such as perceptions of corruption or inefficiency were not brought up by litigants. On the contrary. At some point of the interview, either spontaneously or when asked about it, all 55 interviewees talked about the low quality of government in Brazil – even those working for the Executive power.

3.7 Conclusion

In this chapter I explored how external factors, such as the perception of a corrupt and inefficient health care system, and a wider notion of a 'bad quality' government in Brazil are

[247] Interviewee 21 (2016) Interview with public defender in Rio de Janeiro (RJ) [09/12/2016]

associated with an increase in successful health care litigation by fuelling judges' will to get around an untrustworthy political system.

I analysed how perceptions in Brazil can be detached from the true quality of the public health care system and how people's personal experience or lack thereof have an important bearing in how they perceive the quality of the system. In this context, given that most judges have private health care insurance and do not make use of the public system, their perception of the system's quality is informed by the cases that reach them, how the system is portrayed in the media, and through their own imagination. The result of this perception that the health care system does not work, is judges deep distrust in the government and public authorities, including those responsible for designing and administering the health care system, SUS. As a result of this entrenched distrust, judges showed a disposition to disregard the arguments of the public attorneys defending the state in lawsuits, thus not deferring to the health care authority and granting the request of access to drugs, treatments or devices not included in the public policy.

My argument is that *in order to* be able to reach such decisions and grant the health care claims, judges find a way around the restriction set by the statutes and the public policy regulation, by using rights-based constitutional arguments to invalidate administrative decisions and compel the public authority to provide a drug, treatment or device not included in the policy. A *jeitinho* around the law, but which uses the tools provided by the law (as such described by Ewick and Silbey as 'with the law'[248]).

In 'The Common Place of Law', Ewick and Silbey examine the diverse ways in which the law is understood, felt, and used in the everyday life of people – the commonplace experiences. According to the authors, most times people do not think of the law at all. In

[248] EWICK and SILBEY, *The Commonplace of law. Stories of everyday Life*

others, however, 'the law seems like an all-too-human arena in which people struggle with one another in serious and playful encounters, more or less skilfully, for all sorts of sublime and petty purposes'[249]. Such *use* of the law, which is often played as game, is what the authors call 'with the law'.

> [A] bounded arena in which preexisting rules can be deployed and new rules invented to serve the widest range of interests and values. It is an arena of competitive tactical manoeuvring where the pursuit of self-interest is expected and the skilful and resourceful can make strategic gains.[250]

By playing the game of law, and tactically manoeuvring the legal system to achieve a desired outcome, litigants, third parties (such as pharmaceutical companies) and judges act 'with the law'[251] – which I describe, by drawing from the Brazilian sociological literature discussed in Chapter 3, as a *jeitinho*. A creative (and often unethical) way around perceived systemic problems, solved through the use of the constitutional law for a desired outcome – access to drugs, treatment and medical devices not provided by the health care system, SUS.

These external factors analysed in this chapter are not the only drivers of judicial decisions, however. There are also internal factors which influence judges' decision to grant health care claims. In the next chapter I discuss how interviewed judges talked about their role in society, about how their emotions were important factors behind their decision-making, and how they wanted to use their power to change unjust social situations: "I can make a difference in someone's life. Why shouldn't I?"[252].

[249] Ibid, 15.
[250] Ibid, 48.
[251] EWICK and SILBEY, *The Commonplace of law. Stories of everyday Life*
[252] Interview with first-degree judge in Rio de Janeiro on 9th of December 2016.

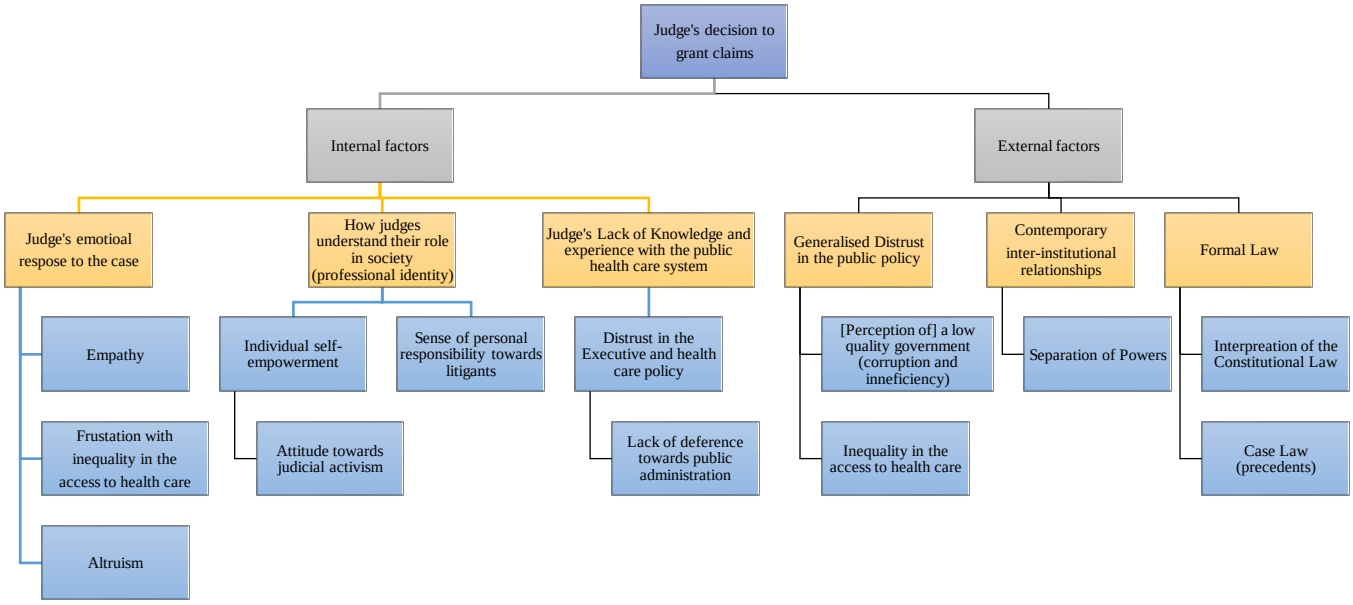
CHAPTER 4 - THE IMPORTANCE OF (BEING) A JUDGE: ALTRUISM AND JUDICIAL SELF-EMPOWERMENT AS FACTORS INFLUENCING SUCCESSFUL HEALTH CARE LITIGATION IN BRAZIL

> What the [Brazilian] judges are doing is to escape the solution foreseen in the written law to pursue a righteous solution. [They act as] the Punisher[253].

In the previous chapter I unpacked the external factors influencing judges' decision to grant health care claims against the state. I focused on how the distrust in the health care public policy and the Executive more generally contribute to judges' willingness to grant access to drugs, treatments, and medical devices not available in the public health care system. Such distrust then interacts with other factors, of a more personal nature, such as judges' empathy towards litigants, their feeling of personal responsibility towards litigants and a self-empowerment. In this chapter I examine how these internal factors (analytically identified in the diagram below) operate within the wider web of socio-legal factors influencing the increase of successful health care litigation in Brazil.

FIGURE 6: SOCIO-LEGAL FACTORS THAT INFLUENCE JUDGES' DECISION-MAKING

[253] Interviewee 8 (2016) Interview with judge from the Superior Court of Justice in Brasília (DF) [18/11/2016]



4.1 Judicial empowerment: a socio-legal analysis of the increase of judicial power

> The legal training is one in legal *and social* sciences. (…) So, our work is not just legal, is social as well. We [judges] need to observe this aspect, that people depend on us[254].

In 1936 Eugen Ehrlich wrote that 'the center of gravity of legal development lies not in legislation, nor in justice science, nor in judicial decision, but in society itself'[255]. Moreover, legal phenomena do not happen by chance or as a mere consequence of isolated legislative and judicial activity[256]. Nonetheless, as Ran Hirschl points out: 'despite the fact that courts now play a key role in dealing with the most contentious social and political issues, the field of (…)

[254] Interviewee 32 (2017) Interview with first-degree judge in Campinas (SP) [16/01/2017].

[255] Eugen Ehrlich, *Fundamental Principles of the Sociology of Law*, translated by Walter L. Moll (Harvard University Press, 1936).

[256] 'Law is a last resort, or a "residual category" as a measure with which societies attempt to control what they cannot control. In other words, rather than building our observational design on the - implausible - assumption of the centrality and special "effectiveness" of law as theories grounded in legal centralism imply, sociological theory suggests that we build our observational design on the assumption of the marginality of law where its social effects are concerned' (Klaus A ZIEGERT, 'Courts and the Self-Concept of Law-The Mapping of the Environment by Courts of First Instance' (1992) 14 Sydney L Rev 196)

judicial empowerment in particular, remains relatively under researched'[257]. Moreover, the literature up to date has mainly focused on legal explanations for judicial empowerment – looking at, for example, constitutionalisation of rights, judicial review and interpretation techniques, or, from a systemic perspective, examining the institutional arrangements[258] that allows for judicial empowerment.

The social element[259] of this equation, nonetheless, is often overlooked[260]. My research contributes to the literature which provides wider sociological explanations of judicial empowerment, by offering an inductive social-legal[261] analysis of judicial empowerment in the case of health care litigation in Brazil.

4.1.1 Defining empowerment: a critical literature review

According to the literature, empowerment happens in two dimensions: as an interior construction of the self or others[262], and as a consequence of actions and behaviours. Also, it

[257] Ran HIRSCHL, *Towards Juristocracy: the origins and consequences of the new constitutionalism* (Harvard University Press 2007) 4

[258] Martin SHAPIRO and Alec Stone SWEET, *On Law, Politics and Judicialization* (Oxford University Press 2002); Ran HIRSCHL, 'The Political Origins of Judicial Empowerment Through Constitutionalization: Lessons from Four Constitutional Revolutions' (2000) 25 Law & Social Inquiry 91; Gretchen; Ríos-Figueroa HELME, Julio, *Courts in Latin America* (Cambridge University Press 2011); Cristina PARAU, *The Role of Courts in Democracy* (Report and Alaysis of a Worshop and Public Debate, 2011)

[259] 'The social environment divides into two parts: one is the legal environment, by which is meant the issues and effects deriving directly from the legal design; the other is the wider social context that interacts with the law and its environment. By introducing the officials responsible for implementing law, we move from the law to its environment.'(Denis GALLIGAN, *Law in Modern Society* (Oxford Scholarship Online 2006) 310)

[260] 'There is little information available about who litigates and why they litigate as there is about who chooses not to litigate and who feels that they are being denied access to the courts. We have surprisingly scant knowledge of the kinds of cases that actually reach the civil courts or the dispute resolution activity that takes place in the shadow of the courts.'(Hazel GENN, *Paths to Justice: what poeple do and think about going to law* (Hart Publishing 1999) 1)

[261] Managing Legitimacy: Strategic and Institutional Approaches [1995] 10 Academic Research Review 574.

[262] "Definitions of empowerment abound. (…) The various definitions are generally consistent with empowerment as 'an intentional ongoing process centered in the local community, involving mutual respect, critical reflection, caring, and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources' (Cornell Empowerment Group, 1989)" (Douglas D PERKINS and Marc A ZIMMERMAN, 'Empowerment theory, research, and application' (1995) 23 American journal of community psychology 569).

can relate to individuals, to the community and to professionals. So, empowerment can be observed as changes in personal levels of empowerment, as social change or as professional intervention.

For empowerment to take place on a personal level there must be a sense that the actor is able to exercise powers over the legal procedures presented to him/her in a positive way. In the context of my research, this means that judges perceive themselves as being qualified to act and willing to use the law and their legal power for a particular end – often altruistically, to improve the life of the litigant (further discussed in this chapter).

From a behavioural perspective, empowerment refers to actions that improve a condition. It can be expressed, for example, (i) as an individual empowering him/herself to benefit others - for example, judges acting where there is a perceived injustice; (ii) as an individual empowering others - for example, litigants individually starting legal action as means of transferring to judges the power to decide a claim, with hopes to improve a personal situation; (iii) as a group empowering other, such as in collective litigation or as part of a coordinate action within the civil society (patient's associations, for instance); and (iv) as people empowering themselves for self-benefit - for example, patients litigating in order to acquire a medical device not available.

Thus, people can legally empower[263] themselves, becoming 'more relevant' and part of the process of decision-making about health care, as well as empower professional legal actors, such as judges, e.g., when litigants start a claim. Empowerment is part of the socio-legal factors that I analyse.

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[263] According to the Open Society Foundations "Legal empowerment is about strengthening the capacity of all people to exercise their rights, either as individuals or as members of a community. Legal empowerment is about grass root justice, about ensuring that law is not confined to books or courtrooms, but rather is available and meaningful to ordinary people." (Available at https://www.opensocietyfoundations.org/projects/legal-empowerment, accessed on 5/6/2016)

For the theoretical analysis about the increase of judicial power, empowerment comes into play as an element in the socio-legal dimension. This is due to the fact that when people choose to take matters of public policy (such as health) to the Judiciary, they are empowering judges and themselves. Similarly, judges are empowering themselves when they decide to rule on policy matters, exerting an influence in the policy which would not 'normally' be thought as roles of the judiciary.

In the case of judicial empowerment, if the judge decides to use their powers to exercise influence over areas normally considered to be outside the scope of judicial intervention, is usually referred to as judicial activism.

4.1.2 Judicial Activism: narrowing down 'a slippery term'[264]

Judicial activism is a theme with many connotations and lacks a uniform definition[265] in the literature, and which is often considered pejorative[266]. Kmiec analytically divides the literature of judicial activism in four groups[267]: (i) invalidation of constitutional actions of other branches of power; (ii) failure to adhere to precedent; (iii) judicial 'legislating'; (iv) departure from interpretative methodology; and (v) results-oriented judging.

The first use of the term 'judicial activism' is attributed to an article authored by Arthur Schleshinger[268], where he counterposes activist judges to the ones who exercise self-restraint.

[264] Frank H EASTERBROOK, 'Do liberals and conservatives differ in judicial activism' (2002) 73 U Colo L Rev 1401

[265] Keenan KMIEC, 'The Origin and Current Meanings of Judicial Activism' (2004) 95 California Law Review 1441

[266] John Q BARRETT, 'Arthur M. Schlesinger, Jr.—in Action, in Archives, in History' (2007)

[267] KMIEC, 'The Origin and Current Meanings of Judicial Activism'

[268] Frank B CROSS and Stefanie A LINDQUIST, 'The scientific study of judicial activism' (2006) 91 Minn L Rev 1752

A differentiation between activism and judicial restraint thus became a feature of the analysis of judicial decision-making.

As Kmiec notes[269], judicial activism is not the same as exercising judicial review. However, when courts 'disallow policy choices by other governmental officials or institutions that the Constitution [or statute] does not clearly prohibit'[270], then the limits of judicial review are extrapolated and enter the arena of judicial activism. The limit, however, is often blurred and depends on the interpretation of the constitutional text. In the case of constitutional rights, which are often loosely defined, the limits of judicial review might be stretched by purposely using extensive interpretation of a broad concept.

Courts are also considered activists when they *use* the law to achieve a goal. In this case, judges would have an ulterior motive for reaching a decision. Although some read this form of judicial activism as partisan – particularly in the context of the United States[271] – a wider interpretation of result-oriented judging can also encompass judicial altruism. Moreover, as I discuss further in section 4.2.3, judges in Brazil describe feeling responsible for the wellbeing of the litigant in cases requesting access to health care litigation, and therefore feel the need to act.

As I will further discuss below, the activism which can be identified in the case of Brazil is *attenuated*. Moreover, health care judicial activism is exercised from the bottom-up, in each individual case, and does intend to alter the policy. Furthermore, judges refrain from seeing their actions as activists, *because* they are in accordance with the law and the Constitution. However, as I discuss in Chapters 4 and 5, the *interpretation* given by courts to legal concepts

[269] KMIEC, 'The Origin and Current Meanings of Judicial Activism'

[270] Lino A GRAGLIA, 'It's Not Constitutionalism, It's Judicial Activism' (1995) 19 Harv JL & Pub Pol'y 293

[271] James P WENZEL, Shaun BOWLER and David J LANOUE, 'Legislating from the state bench: A comparative analysis of judicial activism' (1997) 25 American Politics Quarterly 363

such as separation of powers and the extent of the right to health care as 'the right to everything'[272] are precisely what enables, in the formal legal discourse, the individual activism.

4.2 The Influence of Internal Factors in Judicial Decision-Making

Judicial decision-making has been a subject of academic exploration for decades[273]. Scholars have thoroughly investigated, both theoretically and empirically, the factors that influence the decisions taken by judges from a legal and sociological perspective. In the United States, where the investigation of judicial decision-making is prolific, academics formed different schools to explain *how judges judge*. On the one hand formalist theory[274] understands judicial decision making as the result of a rational, deductive reasoning which takes into consideration solely the rule of law and the facts of the case. On the other hand, legal realists[275] believe judicial decision making is taken based on a hunch rather than on systematic analysis of fact and law. According to this theory, judges decide based on their 'feelings, impulses, and intuition, not by judgment'[276]. These impulses are informed by the judge's legal and political experiences, his/her personal characteristics, education, and social status.

The empirical analysis of judicial decision making in the context of health care litigation in Brazil does not seem to be able to be explained with reference to any of the single theories mentioned above. Rather, as explained in Chapter 3, and as I will further explore in

[272] FERRAZ, *Health as a Human Right: The Politics and Judicialisation of Health in Brazil*

[273] For example, Glendon A SCHUBERT, 'The study of judicial decision-making as an aspect of political behavior' (1958) 52 The American Political Science Review 1007; Timothy J CAPURSO, 'How judges judge: Theories on judicial decision making' (1999) 29 U Balt LF 5; Richard A POSNER, *How judges think* (Harvard University Press 2010)

[274] On formalist theory of judicial decision making, see CAPURSO, 'How judges judge: Theories on judicial decision making'.

[275] On legal realism, see Jerome FRANK, *Law and the modern mind*, vol 350 (Transaction Publishers 1963).

[276] Chris GUTHRIE, Jeffrey J RACHLINSKI and Andrew J WISTRICH, 'Blinking on the bench: How judges decide cases' (2007) 93 Cornell L Rev 1

this chapter, the different internal and external factors influencing judges' decision-making could fit into both theories of judicial decision-making referred to above. For example, judges do rationally interpret and apply the constitutional legal provisions in health care cases - formal decision making, but they are also driven by their distrust in the public policy, their personal empowerment, and their feelings – in line with the elements of judicial decision making considered by legal realists. Therefore, in my thesis I do not limit the scope of my analysis of judicial decision making in health care litigation to the application of any specific theory but seek to generate an inductive explanatory framework, of internal and external factors.

Furthermore, the analysis I undertake in this chapter focuses on judges individually, rather than on courts. More specifically I give a great deal of attention to lower court judges, who are often overlooked by the literature studying judicial decision-making and judicial activism[277]. Moreover, rather than receiving a systematic, coordinated response of the Judiciary as a whole, the massification of individual legal action for access to health care "pulverises" the discussion of access to health care through each individual case, and therefore provides an opportunity for individual judges to exercise their power locally. The exercise of judicial power depends on both legal provisions – i.e., the parameters set by the law to the scope of judicial analysis, and judge's understanding of what their role in society is. This is what I analyse in the next section.

4.2.1 What does it mean to be a judge in Brazil? – judges' construction of their professional identities

> Judges [in Brazil] have a syndrome of saviours of the country, like they were anointed with a special gift of deciding[278]

[277] On judicial activism in Supreme Courts in different jurisdictions: Javier COUSO, Alexandra HUNEEUS and Rachel SIEDER, *Cultures of legality: judicialization and political activism in Latin America* (Cambridge University Press 2010); Kenneth M HOLLAND, *Judicial activism in comparative perspective* (Springer 1991); Shannon Ishiyama SMITHEY and John ISHIYAMA, 'Judicial activism in post-communist politics' (2002) Law and Society Review 719; J Skelly WRIGHT, 'Role of the Supreme Court in a Democratic Society-Judicial Activism or Restraint' (1968) 54 Cornell L Rev 1

[278] Interviewee 49 (2017) Interview with Supreme Court judge in Brasília (DF) [07/02/2017]

How a judge perceives, acts, and feels about the role he/she should play in society as well as to the extent to which he/she thinks judicial intervention in public policy is legitimate, is influenced by his/her construction of what being a judge means. And why is professional identity relevant to understanding the rise of successful health care litigation in Brazil? The answer is the link between the construction of the professional self and a person's agency as that professional. The identity someone constructs for themselves with reference to their profession affects their attitudes and behaviour while exercising their function, even beyond the working environment[279]. In the case of judges, for example, the way they act, and thus how they decide cases, is closely connected to the meaning they attribute to the social and legal role they play in society. Therefore, in the context of a judicialisation of health care, a judge's decision of how far (s)he should decide and interfere into the policy issues (and thus analyse the merits of administrative decisions) encompassed his/her interpretation of what the role of a judge in society should be. As one judge from Rio de Janeiro describes:

> We [judges] would much prefer not having to be activists, because that would mean that the policy would be working. No one wants the judicialisation [of health care] to happen. But, if I must grant it, I will. That is our role [as judges]. (…) When something is not working, we must intervene. (…) We meddle because of an imbalance taking place. We act when an arm of the State fails, and people come asking for help. Then we give help[280].

In the quote, the judge from Rio de Janeiro refers to judicial activism as a response to a public policy which is 'not working'. According to that judge, the judicialisation of health

[279] A profession is very often integral part of someone's identity. Hence it influences how (s)he perceives him/herself and how others perceive them – their self-esteem. For example, an academic or a judge can believe they are more ethical than most people given their profession. Others can also presuppose that judges are more literate than most people by inferring that it is required a lot of study to be one. These social and self-constructions influence how people behave and interact with others inside and outside their professional sphere, and how power relationships are established (on this topic see Riia LUHTANEN and Jennifer CROCKER, 'A collective self-esteem scale: Self-evaluation of one's social identity' (1992) 18 Personality and social psychology bulletin 302)

[280] Interviewee 17 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

care and the judicial response to it is a consequence of the bad health care provided. Such notion is in line with the idea of a generalised distrust in the public policy, examined in Chapter 4. However, the judge goes beyond this. According to him/her, as a response to the [perceived] mal-functioning public health care system it is the judge's responsibility to act. The *role* of judges in those circumstances is to "meddle", to "give help".

The account given by the first-degree judge from Rio and in some way repeated throughout the interviews with 16 out of the 19 judges in Brazil, is that a judicial response is necessary in the context of an inefficient and corrupt state. "Acting" is part of the role of the judge as a public servant who is able to intervene and compensate for "an imbalance taking place".

Even though most judges (15 out of the 19 interviewed) refrained from framing their response as judicial activism or rejected such designation, I choose to use this terminology in a nuanced manner. In light of the definitions of judicial activism, when judges grant claims for access to health care as an individual response to a perceived injustice created by a distrusted public policy, I call this an *attenuated form of judicial activism*.

It is important to stress how this attenuated form of judicial activism is connected to judges' professional identities and their conception of what judicial independence entails. Moreover, the activism observed in health care litigation in Brazil, which takes place in each judge's individual chambers and is realised through each individual case, stems from each judge's understanding of their personal responsibility towards the litigants and their individual empowerment. It is not an institutional, coordinated response of the judiciary to a public policy issue, but an individualised solution by each of the judges in their "comarcas" (districts)[281] – who often, as I explore further in this chapter, find different solutions to the problem.

[281] The Judiciary in Brazil is divided mainly between two main jurisdictions – federal and state, which are then further divided into five regions of federal justice and 27 state courts. In the first degree, the Judiciary is divided into 2702 state *comarcas* (districts) which are geographically defined (data from (CNJ), *Justiça em Números*)

This individual (attenuated) judicial activism is made possible due to judge's interpretation of judicial independence as the freedom of each judge to decide according to their better judgement, free from pressure or restriction from other institutions and from other ranks of the Judiciary itself. One judge from Rio de Janeiro, for example, reflecting about the possibility of the Supreme Court[282] limiting judge's power to decide health care cases, says:

> Limiting the cases in which the judge can grant medicines is a problem. (…) Because the fact is that when the citizen has a problem and there is no other door open for them, they will knock on the door of a judge. [If their power is limited] this judge will not be able to help this citizen, who will have no solution [to their problem]. What is the alternative for enforcing a right through courts? What will that person do? What will happen is that we will go back to the Brazilian way [*jeitinho*] of solving thing: "Do I know someone who knows someone in the health care sector who can help me" or "call someone with authority get my son a place in school". So, you cannot limit the power of judges[283].

This individualised conception of judicial independence, expressed by the judge's quote above, is also in line with the argument of some Brazilian scholars who understand, for example, that binding precedents are unconstitutional under the Brazilian civil law system[284]. According to them, the principle of judicial independence reflects not only the institutional independence of the Judiciary from the political pressures exercised by other powers, but also the judge's individual independence to decide according to his/her beliefs and legal judgement.

[282] This limitation refers to the decision of the Supreme Court in the case RE 566471/RN, not yet concluded in the time of the interview, which set boundaries for concession of drugs and treatments not yet approved by ANVISA (RE 566471/RN, Marco Aurélio Mello, Brazilian Supreme Court (2020)).

[283] Interviewee 17 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016].

[284] Georges ABBOUD, 'Sentenças interpretativas, coisa julgada e súmula vinculante: alcance e limites dos efeitos vinculante e erga omnes na jurisdição constitucional' (2009) ; Waldemar Claudio de CARVALHO, 'A súmula vinculante e a independência funcional do juiz' (2017) ; Antônio de Pádua RIBEIRO, 'A súmula vinculante e a independência jurídica do juiz' (1997) 2 Revista da Escola Superior da Magistratura do Estado de Pernambuco–ESMAPE

Such individual independence would thus include not bounding judge's decision-making to decisions of the higher courts. Rather, judges could only be limited by the written law[285].

The individual solution given by each of the judges in Brazil is also reflected on the lack of uniformity between the legal criteria, procedure, and decisions given. Very often judges talked about the quality of decisions taken in their *comarcas* (district), how *they* resolved cases, in opposition to how other colleagues or the higher courts decided. Frequently judges criticised how other judges and courts decide health care cases, how they employed strategies of enforcement or granted requests they themselves would not. For example, a judge from Araraquara, in the countryside of São Paulo, reflects about her/his decision-making process. (S)he starts by explaining why (s)he does not think deciding health care lawsuits in favour of litigants is an exercise of judicial activism, and then continues to explain what legitimates these decisions:

> There is the principle of jurisdiction inertia; the judge has to be inert; this means I do not leave my office seeking claims, the attorney is the one who brings me (the lawsuit). However, when judges seek additional information, (…) I think (s)he is making a contribution to the greater principle of (…) jurisdiction's effectiveness. What I mean by jurisdiction effectiveness is that we [judges] are here to fulfil a role which is not merely bureaucratic. For example, the civil proceedings must be observed with respect to equality between the parties. However, if we respect equality between the parties strictly, a pillar of democracy is shaken. [On one side of a litigation] we can have economic forces (…) that are stronger than less favoured ones [on the other side of a lawsuit]. So, when the judge corrects this imbalance, even if the party has not taken the initiative of asking for it, I think the judge is actively fulfilling his/her role. What's that role? To give the best right to whoever knocks on the Judiciary's door. That is effectiveness of the jurisdiction.[286]

The interpretation given by the judge from Araraquara of what (s)he considers to be the best translation of the 'effectiveness of jurisdiction', or, in other words, what the exercise of

[285] Georges ABBOUD and Marcos de Araújo CAVALCANTI, *Inconstitucionalidades do incidente de resolução de demandas repetitivas (IRDR) e os riscos ao sistema decisório* (2015) ; Cláudia Maria BARBOSA, 'Independência do Poder Judiciário e Súmula Vinculante' 1 Revista do Direito Privado da UEL

[286] Interviewee 11 (2016) Interview with first degree judge in Araraquara (SP) [23/11/2016]

his/her role as a judge ought to be, is grounded in individual actions rather than systemic solutions. In other words, when the judge emphasises that when each person who 'knocks on the door of the Judiciary' (s)he has to provide the litigant with the 'best right', (s)he is looking for the best individual solution to that case. Hence, to solve a perceived problem of inadequate health care service – represented in the refusal to provide a drug or treatment - the judge believes (s)he needs to decide according to his own capabilities and beliefs (including his/her distrust in the public policy). This makes the judge an individual solution-maker, not part of the wider, coordinated institutional framework of the Judiciary. The different solutions given by judges in individual cases are atomised rendering the outcome of cases uncertain – even if a judge grants a claim, their thresholds and ways of enforcement can vary widely. This inconsistency arising from the individual judge's activism (or attenuated form of activism), is what the literature calls a judicial lottery[287].

This individualist solution approach to decision-making in health care litigation can be observed amongst the interviewed judges in Brazil, as well as among the litigants interviewed. For that reason, the theme of individualism will be revisited in Chapter 7 with reference to the litigant's decision to start litigation and the behaviour of third parties, such as pharmaceutical companies, who benefit from and influence health care litigation.

Judicial individualism also resonates with literature which examined the Brazilian Supreme Court and the relationship between the eleven judges who form it. On several occasions, academics and commentators have raised the issue of how the Supreme Court justices in Brazil act as eleven isolated islands, instead of one unified Court[288]. This analysis

[287] Claudia Maria BARBOSA and Elson Pereira DE OLIVEIRA BASTOS, 'Precedentes Obrigatórios, Desenvolvimento e Segurança Jurídica' (2018) 19 Revista Eletrônica de Direito Processual , José Lúcio Monteiro DE OLIVEIRA, 'Precedentes Judiciais e Segurança Jurídica', PUC-Rio 2014)

[288] Felipe RECONDO and Luiz WEBER, *Os Onze: O STF, seus bastidores e suas crises* (Editora Companhia das Letras 2019); Wagner Wilson Deiró GUNDIM and Thiago Pellegrini VALVERDE, 'Justiça aristotélica e as onze ilhas do supremo tribunal Federal: a possibilidade de Justiça no caso concreto' (2017) Revista da AGU

comes not only from the political disputes inside the court, but from the number and importance of decisions taken individually by justices[289], without submitting it to the collegiate scrutiny. For example, as explored in Chapter 3, in 2015, Justice Facchin granted, in an individual decision (monocratic), the supply of the substance *fosfoetalonamina*, still in trial stage, known as the *cancer pill*[290]. The decision generated significant effects for the budget and administration of health care throughout the country. Weeks later it was overturned by the collegiate[291], after the medical community and the policy makers emphasized the danger of forcing the system to buy and supply a drug still in trial stages – i.e., before approval of ANVISA.

> I thought that impartiality had a bit of neutrality. But it does not. The judge must be impartial but not neutral. It is not even good for a judge to be neutral; we must have personal positions[292].

In this context of individualism, the choices made by one judge, acting in the belief that (s)he is doing what is best for the case under their scrutiny, greatly varies from the choices of another adjudicator. For example, during interviews, judges referred to different standards *they* adopted in health care cases – i.e. 'I know judges that grant experimental drugs, but I only grant drugs approved at least by other agencies around the world'[293]. They also talked about numerous different "solutions" adopted when the state did not comply with their decision. For example, whilst some judges believed that arresting a mayor or governor when a judicial decision was disregarded and the drug or treatment not supplied was the best way of enforcing

[289] Diego Werneck ARGUELHES and Leandro Molhano RIBEIRO, ''The Court, it is I'? Individual judicial powers in the Brazilian Supreme Court and their implications for constitutional theory' (2018) 7 Global Constitutionalism 236ibid

[290] PET 5828, Min. Edson Fachin, Supreme Court, Brazil (9/10/2015)

[291] ADI 5501 MC, Min. Marco Aurélio Mello, Supreme Court, Brazil (19/5/2016)

[292] Interviewee 26 (2016) Interview with first-degree judge in São Paulo (SP) [21/12/2016].

[293] Interviewee 32 (2017) Interview with first-degree judge in Campinas (SP) [16/01/2017]

the judicial decisions, others said that same measure was 'absurd'[294], or affirmed having done it before but as a 'desperate strategy'[295]. In other cases, some judges understood that in case of lack of budget in the health care system of a district or state, they could determine that the moneys required to pay for a litigant's drug be taken from another public budget, such as marketing, 'if that is what it takes'[296]. Others would refer to such solution saying: 'I know of colleagues who do that. I have done it, but today I think is nonsense. It does not work'[297] or that these actions were those of judges who 'thinking he can do whatever he wants'[298].

The individualised approach to judicial decision-making creates a judicial lottery[299] which is widely criticised by the legal literature, not only in relation to health care lawsuits[300]. The case-by-case approach reflected in the individualised, attenuated activism observed in Brazil, is influenced by judge's professional identities and by the self-empowerment described as 'the power of the cloak'.

4.2.2 The power of the cloak: how judicial self-empowerment influences the rise of successful health care claims in Brazil

> Systemically, the [judicialisation of health care] is not good from the point of view of [policy] efficiency. (…) But I do not regret deciding in favour of the citizen. Not at all. I actually feel really good about it. At the same time deciding in such a way gives me a personal anguish, it also gives me a feeling of empowerment.[301]

[294] Interviewee 40 (2017) Interview with appellate court federal judge in Curitiba (PR) [23/01/2017]

[295] Interviewee 17 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

[296] Interviewee 16 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

[297] Interviewee 26 (2016) Interview with first-degree judge in São Paulo (SP) [21/12/2016]

[298] Interviewee 40 (2017) Interview with appellate court federal judge in Curitiba (PR) [23/01/2017]

[299] Álvaro FERRAZ, *Microssistema de precedentes judiciais vinculantes do CPC/15 e a gestão de processos* (Fórum 2020)

[300] Bruno DANTAS, 'A jurisprudência dos tribunais e o dever de velar por sua uniformização e estabilidade' (2011) Revista de Informação Legislativa ; André LAGE-FREITAS, Héctor ALLENDE-CID, Orivaldo SANTANA *and others*, 'Predicting Brazilian court decisions' (2019) arXiv preprint arXiv:190510348

[301] Interview with first degree judge from Rio de Janeiro on December 9th, 2016.

For the late Judge Jerome Frank, of the United States Court of Appeal, the judicial robe was a power symbol that produced awe and fear in others and inflated the ego of the adjudicator wearing it[302]. The power of the cloak (or power of the pen, as it is said in Portuguese) was a recurrent thematic during interviews with judges in Brazil. At one point, all 19 interviewed judges mentioned the strong power they possessed to impact the litigants' lives or to better the situation for some. On several occasions judges would bring up their justifications for deciding in favour of litigants – i.e., the distrust in the public policy, then adding the caveat: 'and, I have the power to do it'. One justice from the Superior Court of Justice in Brasília, for example, expresses his/her view that judicial review in health care cases is not bad in itself. However, the "over empowerment*"* of individual judges throughout the country trivialises it, producing inefficiency and budgetary chaos. In his/her words:

> The judicialisation of health *per se* is not entirely bad, however the way it is done in Brazil is problematic, because it is indiscriminate, and judges feel over empowered to take any decision, grant any request, in a way that compromises the effectiveness of the health care system and the public budget[303]

The critical assessment made by the Superior Court Justice in the quote about the over empowerment of the individual judge's reflects the lack a more systematic response of the Judiciary to the health care legal claims. The individualised approach is, however, made possible by the lack of a tighter legal framework of judicial review, and a weak judicial culture of adherence to precedents. Moreover, as I explain further in Chapter 5, Brazil's system of judicial review allows for wide controls of legality and constitutionality of administrative decisions by any judge. It also lacks clear boundaries for the reach of judicial intervention – i.e., if judges are allowed to review the merits of administrative decisions. Furthermore, the

[302] Robert A. KESSLER, 'The Psychological Effects of The Judicial Robe' (1962) 19 American Imago 35

[303] Interviewee 4 (2016) Interview with judge from the Superior Court of Justice in Brasília (DF) [17/11/2016].

judicial culture of adherence to precedent is still embryonic in Brazil. Albeit the law already provides for a few cases of binding precedent, such as the *súmula vinculante* and cases decided by the Supreme Court under *repercussão geral*, most decisions from higher courts are not binding to lower judges. Therefore, judges understand that in the vast majority of circumstances they hold, individually, the power to decide claims according to their better judgment.

But the judicial self-empowerment does not just stem from the formal legal framework. It also encounters support in their perceived technical competence to decide such cases. According to a Justice of the Supreme Court:

> [In Brazil] judges are more qualified than other institutions (…). To be a judge [in Brazil] you must (…) pass a public entrance examination (…) which is serious and difficult. This created a qualification threshold for judges, (…) which did not take place in the Legislature[304]

The quote from the Justice accounts, at the same time, for a distrust in the competence of politicians and the recognition of the competence of judges, given the selection process they must go through. Moreover, to become a first-degree judge in Brazil, the candidate must hold a law degree – which requires undergoing five years of law school – be a licensed lawyer – thus pass the bar exam - and practice for three years. After that, the candidate can apply for the public entrance examination (*concurso público)*, which is organised and controlled internally by the state courts and federal courts – thus by judges themselves. Each examination usually takes around six months and is comprised of a thorough selection process divided in five phases – a multiple choice test, a written test, an investigation of previous life and an oral examination – and, as mentioned by the Justice, it is extremely competitive. For example, in the 2018 public

[304] Interviewee 49 (2017) Interview with Supreme Court judge in Brasília (DF) [07/02/2017].

entrance examination to become a judge in the state of São Paulo, there were 23.122 candidates to fill 86 positions. That is equivalent to 268 candidates per position.

The years of study - on average 2,5 - to be approved are well rewarded: Brazilian judges are amongst the best paid judges in the world[305] and enjoy stability for life[306]. Being approved in a *concurso público* represents a symbol of power, prestige, and intelligence[307]. The public entrance exam offers a legitimation from the impartiality of an examination-based selection of the most competent candidates. This counterposes, for example, the perceived clientelism in the appointment of the Executive and lack of technical competence of the Legislature. According to a state's attorney from Santa Catarina:

> Judges think that because they passed a public entrance examination, they are better than everyone else […] and can do the job of the Executive and the Legislature[308]

Often the 'power of the cloak' – or 'power of the pen' – is referred by judges as a necessary evil when the public power does not act. For instance, a judge from the Superior Court of Justice, reflects about how he 'gives a chance' to the public authority to act before deciding:

> Before granting [a drug or treatment in a lawsuit], I try to contact the state's authority saying 'Governor, this happened… It looks like it is an easily solvable situation (…). So, resolve it, or don't come telling me later that I didn't warn you, that I didn't call

[305] "One in São Paulo recently pulled down $361,500 in a month. That is not a typo: some judges in Brazil are paid more in a single month than their counterparts in high-income countries earn in an entire year. The top annual salaries for judges in New York State are climbing to around $198,600" (https://www.nytimes.com/2013/02/11/world/americas/brazil-seethes-over-public-officials-super-salaries.html)

[306] Hustana Maria VARGAS, 'Sem perder a majestade:"profissões imperiais" no Brasil' (2010) 15 Estudos de Sociologia ;

[307] Fernando DE CASTRO FONTAINHA, Pedro Heitor Barros GERALDO, Alexandre VERONESE *and others*, 'O concurso público brasileiro e a ideologia concurseira' (2015) 16 Revista jurídica da Presidência 671; Luiz Carlos BRESSER-PEREIRA, 'Burocracia pública e classes dirigentes no Brasil' (2007) Revista de Sociologia e Política 9

[308] Interviewee 45 (2017) Interview with public attorney for the state of Santa Catarina in Florianópolis (SC) [02/02/2017].

> first (…). What I don't want is the population suffering'. If [after my contact] he doesn't do something about it: "pen" [referring to his/her decision granting the claim][309]

Therefore, judicial empowerment in Brazil is a result of a set of interconnected factors, which include the legal structures – i.e., the constitutionalisation of rights[310], and the lack of more defined boundaries of judicial review (Chapter 5) – and the self-identification of judges as agents of change, who have the power and the responsibility to act when called to do so. Especially in the context of generalised distrust in the public policy and public officials' will and competence to fulfil the constitutional promise of universal health care, judges feel compelled to exercise their power. Judges' strong awareness of their own ethics and values, and their technical competence, empowers them to decide individual claims according to their sense of justice and righteousness, independent of the cost this has for the State: 'if the litigant is poor and there is an expert opinion to grant it, I will. I do not care about the price'[311].

However, as said by British Member of Parliament William Lamb in 1817, 'the possession of great power necessarily implies great responsibility'[312]. Alongside the sense of empowerment expressed by judges, comes a sense of duty to "do something" about the suffering endured by Brazilians and represented by the litigant who 'knocked on the Judiciary's door' for help.

4.2.3 The importance of emotions and the exercise of judicial altruistic authority in health care litigation

> We have close contact with people, so I am touched [by their stories]. I am moved when in front of a person who needs medical treatment to the same extent that I am moved

[309] Interviewee 8 (2016) Interview with judge from the Superior Court of Justice in Brasília (DF) [18/11/2016].

[310] Ran HIRSCHL, 'The Political Origins of Judicial Empowerment through Constitutionalization' (2000) 25 Law & Social Inquiry 91

[311] Interviewee 11 (2016) Interview with first degree judge in Araraquara (SP) [23/11/2016]

[312] Thomas C HANSARD, *Parliamentary Debates: Official Report:... Session of the... Parliament of the United Kingdom of Great Britain and Ireland*, vol 12 (1812)

> when in front of a person who, for example, was the victim of a fraud and cannot recover his only property[313]

Emotions and cognition are often understood by legal scholars as separate factors[314]. As if the law could only have room for rational processes. 'Consequently, emotion is constructed as "other" in law'[315]. Often lawyers who debated the role of emotions in legal processes emphasised the importance of controlling it, due to its uncontrollable, anarchic facet. For social scientists, however, emotions cannot be isolated from cognition and the body.

In the context of health care litigation in Brazil, emotions were described by 13 of 19 interviewed judges as important factors influencing their decision to grant health care claims. The emotional factor described by judges during interviews in Brazil was related to a sense of empathy for the litigant and personal responsibility for the outcomes resulting from the lawsuit – i.e., the possibility of death or the considerable increase of the litigant's quality of life.

The emotions described as empathy for the litigant's situation were particularly important in the accounts of first-degree judges. Moreover, according to them, judges in lower courts have a much closer connection to the litigants. They are often based in small towns, where the personal contact with the population is more intense than in bigger cities or higher courts.

> For me there is a total identification [with the cases]. I need to admit that if ever I am not sure about granting the drug, I will grant it. Even in doubt. And [the identification with the case] is not inherent to the cases involving medication. (…) The judge has a lot of close contact with people. In everything the judge does, at least in the first degree, there is a very strong component of emotions[316].

[313] Interview with first degree judge from Rio de Janeiro on December 9th, 2016.

[314] Bettina LANGE, 'The Emotiona Dimenson in Legal Regulation' (2002) 29 Journal of Law and Society 197

[315] ibid

[316] Interviewee 16 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016].

The same perception, that judges in the lower courts are more susceptible of being influenced by emotional factors, was also mentioned by higher court justices, who though that in order to reduce the number of successful claims the higher courts had to remove from lower court judges the emotional burden of deciding health care claims. According to a Justice from the Superior Court and one from the Supreme Court, for example:

> I think there is a stronger component of emotions involved in saving the person the judge is looking in the eyes, than an evaluation of the public policy. That is why I am trying to create some criteria, to take the emotional pressure out of the first-degree judge[317].

> This is a very delicate problem because it involves people who are sick. Disease is an anguish, so it creates anguish in the lawsuit, and this has an impact, obviously, in the judicial decisions. It impacts the emotions. The judge can't shield his/her feelings like that. (…) Imagine a judge in a small community, where (s)he knows everyone, and there is a claim from sick person (s)he knows, who sees in the drug they are requesting their salvation…[318]

Another facet of the emotional component of judicial decision-making was the relatability judges felt to the situations faced in health care lawsuits. The fact that judges could see themselves in the same position of litigants - for example, having to pay for a high-cost drug for treatment of cancer and not being able to afford it. That relatability increased judge's willingness to grant the drug or treatment requested in the lawsuit. For example, a judge from São Paulo compares different situations involving social-economic rights with different relatability outcomes for judges:

> [The judicialisation of health care] is very complex. For me it's very emotional, when a case involves health, and it involves lives. If I don't grant (the claim) the person can die. [pauses] However, is interesting to think that the feeling is different when deciding children's rights: (…) because health care is universal, it affects the judges too. (…) What if I am myself sick and the treatment costs R$20,000, R$30,000, R$50,000? How

[317] Interviewee 49 (2017) Interview with Supreme Court judge in Brasília (DF) [07/02/2017].

[318] Interviewee 1 (2016) Interview with a Supreme Court judge in Brasília (DF) [16/11/2016].

> will I pay for it? So, we [judges] put ourselves in the place [of the claimant]. But when analysing a case of a fostered child, for example, there is no such identification. Most judges never saw their own children [in the same situation as the] fostered child. Therefore, there is a matter of empathy which interferes a lot in the decision. (…). There is no escaping from these factors, they interfere a lot. You won't read then in the written decision, but they interfere[319]

Empathy can be simply defined as understanding another person's experience by imagining oneself in that other person's situation[320]. It is not a purely emotional process, but a rather cognitive one. It requires from the observer the capacity to comprehend, from knowledge, feeling and personal experience, another person's perspective. Therefore, when the observer has experienced a similar situation of that in which the object of his/her observation is inserted – in this case the judge analysing the situation of a litigant – than the empathetic process is easier and stronger[321]. This is what the judge from São Paulo invoked when he compared situations which he could relate to and others that he did not, and how those affected his/her decision-making behaviour. The experience of this judge is in line with a growing, albeit new literature on empathy and judicial behaviour. For example, in an interesting quantitative study of empathy and judicial decision making, Adam Glyn and Maya Sen found that 'conditional on the number of children a judge has, judges with daughters consistently vote in a more feminist fashion on gender issues than judges who have only sons'[322]. The researchers' results quantitatively show that personal experiences influence how judges make decisions, and that empathy is an important component of those processes.

[319] Interviewee 38 (2017) Interview with first-degree federal judge from São Paulo (SP) [22/01/2017].

[320] Benjamin MP CUFF, Sarah J BROWN, Laura TAYLOR *and others*, 'Empathy: A review of the concept' (2016) 8 Emotion review 144 and Efrat KEREM, Nurit FISHMAN and Ruthellen JOSSELSON, 'The experience of empathy in everyday relationships: Cognitive and affective elements' (2001) 18 Journal of Social and Personal Relationships 709

[321] LAMPREA, 'Colombia's right-to-health litigation in a context of health care reform'

[322] Gerald A GLADSTEIN, 'Understanding empathy: Integrating counseling, developmental, and social psychology perspectives' (1983) 30 Journal of counseling psychology 467

Emotions are thus an important internal factor influencing judges' decision when balancing the interest of the collective and the right of the individual litigant to access a drug, treatment or medical device. Moreover, when faced with lawsuits against the state seeking provision of drugs or treatments not covered by the public health care policy, judges must decide which of the two values weigh more: the individual right to health care or the efficiency of public administration.

> We [judges] are aware of the negative cumulative effect of granting these drugs [via individual litigation]. But we take on the risks to do what is right for the person who needs the medication[323].

The weight of the emotional factors added to the sense of personal responsibility and empowerment resulted in altruistic decision-making by judges, who voluntarily seek to help the litigant as an outcome of their decision.

Altruistic judicial decision-making

The literature has different definitions and understanding of what altruism is[324]. For the purposes of this research, altruism is understood as behaviour that has a goal to benefit another person and is intentionally and voluntarily performed[325]. Moreover, the emotional accounts of judicial decision-making described above held all the components of an altruist act: it was done voluntarily and intentionally – even when the burden to the public budget were high and judges were conscious of their decision's impact– and aimed at benefiting another.

[323] Interviewee 17 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

[324] A literature review of altruism is done by Jane Allyn PILIAVIN and Hong-Wen CHARNG, 'Altruism: A review of recent theory and research' (1990) 16 Annual review of sociology 27 and Robert WUTHNOW, 'Altruism and sociological theory' (1993) 67 Social service review 344

[325] PILIAVIN and CHARNG, 'Altruism: A review of recent theory and research'

As a consequence of performing an altruist action, especially in a context of perceived injustice, the judge then feels empowered by the outcome of his/her action. For example, a first-degree judge from Rio de Janeiro admits (s)he feels empowered and proud by granting the requests in health care lawsuits against the state, because of the social good (s)he believes derives from it[326]. This perceived social good delivered from their actions are, in some cases, reinforced by personal experiences of gratitude experience by judges:

> There was one case of cardiac surgery in a child. The mother came back with the child to thank me. (…) Every month the wife [of one litigant who received a medication through a lawsuit decided by him/her] comes to my office with cake. Every month she takes orange cake, chocolate cake. [This is an example of how] people are grateful for our decisions because it interferes directly in life. So that, indirectly, is empowering because it feels like a good deed[327].

For some judges the circumstances of some cases, and the context in which they are inserted, can have deeper impacts on their sense of social responsibility and thus act in an ever more altruistic way, sacrificing themselves personally to help the litigant. For example, faced with what they called an 'impossible situation' and feelings of deep anguish, a first-degree judge from Rio de Janeiro takes the altruism and voluntarism to a personal level. According to him/her:

> I lost count of how many times I paid for the drug [the litigant requested] because I gave the order for the State to deliver it but when the bailiff went to get it, there was no drug in stock. Then I tried [and a second way] to seize the public money directly from the State's account, but then there was no money. I faced this situation a thousand times. I took the money out of my own pocket and paid for the drug the litigant needed[328].

[326] Interviewee 16 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

[327] Interviewee 16 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016].

[328] Interviewee 17 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016].

Therefore, emotions are important internal factors influencing judicial decision-making in health care litigation in Brazil. Judge's self-identification and empathy with the litigants' cases is a catalyst to the perceived injustice and overall sense of distrust in the public policy. These factors influence an altruistic behaviour which is enabled by their self-empowerment (as competent agents) and a sense of personal responsibility towards the litigant. This complex web of interrelated internal and external factors produces a form of attenuated judicial activism which is exercised case by case by individual judges around the country.

Part of the attenuated nature of the judicial activism identified in health care claims stems from the fact that several judges are not willing to identify their actions as activists. Rather, they describe their actions as individual enforcement of a right to health care provided for in article 196 of the Constitution.

> I am a judge, not a doctor. If someone comes to me with a medical prescription which says that he/she needs a particular drug, and there is a provision in the Constitution saying that he/she has the right to health care, what will I do? Judges don't have to be careful [of what will impact the policy][329].

This legal justification of the individual judicial activism given by judges also reflects what is addressed by the written decisions. Moreover, as I analyse in the next Chapter 5, the published judicial decisions do not reveal the internal and external factors examined so far. Rather, they provide a formal legal justification in hindsight.

4.3 Conclusion

In conclusion, in this chapter I offer an explanation about how the internal factors identified through the interviews with 19 judges from all levels of jurisdiction in Brazil interact

[329] Interviewee 11 (2016) Interview with first degree judge in Araraquara (SP) [23/11/2016].

with the external factor examined in Chapter 3 and influence the increase of successful health care litigation. The main findings point to the relevance of judges' professional identity as individual agents of change, responsible for compensating for a perceived lack of quality of the public policy and social injustice. Judges' self-empowerment combines their sense of a technical and ethical capacity – often superior to other public officials from the Executive and Legislature, with their understanding of judicial independence as an authorisation to take action, individually. Furthermore, judge's emotional response to the cases brought before them, both as self-identification and empathy for the litigants, also encourages them to grant the claims as an altruistic act. These factors are then intensified in a context of perceived injustice and inequality. As a response to judge's distrust in the health care policy and the Executive bodies responsible for it, they empower themselves to "fix" the situation by granting the individual claims for access to health care. A *jeitinho* around a systemic problem which is resolved through the "power of the pen".

In the next Chapter 5 I look at how judges use the constitutional law to provide a formal legal justification to their decisions, in hindsight, and how the extensive interpretation of the right to health care enables them to exercise this attenuated form of judicial activism.

CHAPTER 5 – EXPLORING THE LEGAL IN SOCIO-LEGAL: UNPACKING THE RELATIONSHIP BETWEEN SUBSTANTIVE CONSTITUTIONAL LAW AND THE SOCIOLOGICAL FACTORS INFLUENCING HEALTH CARE LITIGATION IN BRAZIL

> You will tell me 'but the judge cannot [grant these claims], from a legal standpoint, because of the separation of powers, because you were not elected' etc. You want to talk about this issue from the point of view of the law? This is not what interests me most. Although my decisions express just that - the law. My decisions are in blue, there is nothing pink in them. The reasoning is the constitutional right [to health care]. (…) But I don't think that is what matters, other things are more important[330].

To classical jurists and philosophers, law should be anchored in reason rather than passion[331]. 'The law is reason unaffected by desire', professed Aristotle[332]. According to such understanding, in judicial decision-making reason would translate into legality[333] and the observation of the rule of law[334]. However, there are important factors which influence judicial decision making, and they very often do not appear in the published judicial decisions – here I am talking about emotions[335], cultural biases[336] and even lack of technical knowledge of the topic being discussed in the lawsuits. Albeit important and sometimes central to the decision-making process, these deeper layers of judicial decision-making are seldom explicitly referred to in the formal legal text – i.e., the reasoning of judicial decisions. As the judge from São Paulo points out in the quote transcribed above, the key problem of access to health care litigation in Brazil does not concern (just) the law, but other 'more important things'.

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[330] Interviewee 27 (2016) Interview with first-degree judge in São Paulo (SP) [22/12/2016].

[331] Terry A MARONEY, 'The persistent cultural script of judicial dispassion' (2011) California Law Review 629

[332] In Edward DE GRAZIA, 'Humane Law and Humanisitic Justice' (1988) 10 Cardozo L Rev 25

[333] Hans KELSEN, *General theory of law and state* (The Lawbook Exchange, Ltd. 1999)

[334] John RAWLS, *A theory of justice* (Harvard university press 2009)

[335] Richard L WIENER, Brian H BORNSTEIN and Amy VOSS, 'Emotion and the law: A framework for inquiry' (2006) 30 Law and Human Behavior 231 and Hayley BENNETT and Gerald Anthony BROE, 'Judicial decision-making and neurobiology: the role of emotion and the ventromedial cortex in deliberation and reasoning' (2010) 42 Australian Journal of Forensic Sciences 11

[336] Masua SAGIV, 'Cultural bias in judicial decision making' (2015) 35 BCJL & Soc Just 229

The arguments and evidence presented in chapter 3 and 4 contradict the formalist notion of judicial decision making as a *purely* juridical phenomenon[337]. Through the interviewed judges' own words, we can identify a myriad of factors which are not identified in the cold letter of the law as set out in the published judicial decision. What role, then, does the formal law play in the wider socio-legal phenomenon of health care litigation? How does it interact with these other sociological factors?

Given that the aim of this thesis is to understand the main socio-legal factors influencing the rise of successful health care litigation in Brazil, it is important to comprehend how the law interacts with the sociological factors analysed in the previous chapters 3 and 4. Moreover, litigation cannot happen without the formal law. Litigation is only made possible in accordance with the established legal procedures and legitimised by law's authoritative language[338]. In this sense, the law is hereby considered as an external factor influencing health care litigation. Even though the interpretation given by judges of the constitutional law, as an internalisation of the wider legal and sociological context can be identified as an internal factor, the separation I draw here between legal factors as external factors and internal factors, serves as a heuristic device for simplifying the analysis. This chapter thus aims at understanding what is the role of the law, and particularly of the substantive constitutional law, as a factor influencing the rise of successful health care claims in Brazil. I examine *how* the law is *used* within the wider socio-legal phenomenon of an increase in successful health care litigation.

To answer this question, I look at how the interviewed judges justify their decisions to grant access to health care against the SUS in their published decision using formal legal discourse. I then compare the reasoning of the published judicial decisions with the findings of

[337] Ernest J WEINRIB, 'Legal formalism: On the immanent rationality of law' (1987) 97 Yale lj 949

[338] Caroline HUNTER, Emilie CLOATRE, Jiri PRIBAN *and others*, *Exploring the'legal'in Socio-legal Studies* (Springer 2019)

the interviews to identify how and if the sociological factors identified in the interviews are considered in the published decisions. Finally, I look at how an extensive interpretation of the constitutional right to health care provided for in article 196, which Octavio Motta Ferraz calls a 'right to everything'[339], enables a formal legal justification for judges to grant health care claims.

In the first part of the chapter (section 5.1) I focus on how the constitutionalisation of rights, and particularly the interpretation of a right to health care provided in article 196 of the Brazilian Constitution, are used as the core legal argument for decisions granting health care claims. In section 5.1 I analyse how the judicial decisions granting drugs and treatments not covered by the SUS usually rely exclusively on the evidence produced by the plaintiffs in detriment to those presented by the State's defence. For instance, one first-degree judge says:

> The party presents a medical report, a medical document saying that that person has to take that particular medicine. Will the judge say no? Of course, not.[340]

In the second part of the chapter (section 5.2) I explore the themes that are not present in the legal reasoning of published judicial decisions, but are central in judge's interviews. I then discuss how the substantive constitutional law is manoeuvred as an instrumental tool for 'hindsight' justification.

5.1 Methodology – text mining

To answer the questions proposed in this chapter, I conducted a textual analysis of 700 decisions given in the last 10 years by the 19 judges interviewed in Brazil – which included 4

[339] FERRAZ, *Health as a Human Right: The Politics and Judicialisation of Health in Brazil*

[340] Interviewee 11 (2016) Interview with first degree judge in Araraquara (SP) [23/11/2016]

judges of the Supreme Court, 3 judges of the Superior Court of Justice, 4 appellate court judges and 8 first-degree judges selected through snowball sampling[341]. These decisions were selected by searching for the keywords 'SUS', 'ANVISA' and 'acesso (access)', 'right to health' and '196' in each of the states and federal court's case management systems ('jurisprudence' search), specifically filtered by judge and last 10 years. The outcomes of those searches did not result in a proportional number of decisions, given the difference in technical advancement and availability of digitalised decisions in each of the courts' systems, and to the fact that first-degree decisions are often non available in the jurisprudence search system. Therefore, the number of decisions analysed in this chapter is not standardised. After pre-selecting, up to 100 decisions per judge, I eliminated those which had a procedural resolution, and did not discuss the merits of the litigation. Only decisions which discussed the matter of access to health care via SUS were considered.

Once selected, all 700 decisions were then inputted into Python. For the text mining of those I ran a search into pre-defined keywords, in Portuguese (table 2) chosen based on the factors described during interviews (legal and sociological), previous textual analysis of health care litigation decisions in Brazil[342] and my previous knowledge of the topic. Since decisions were originally written and published in Portuguese, the searched terms were also in Portuguese and are translated in the charter below.

It is important to stress that the exercise I undertake in this section is not supposed to be taken as a statistical quantitative analysis of legal justification in health care litigation in Brazil[343]. I do not suggest that the results from the textual analysis here undertaken can be extrapolated to the whole country or even as a separate, statistical finding about the judges who

[341] More about the methodology to select the judges interviewed and the states selected can be found in Chapter 1.

[342] DE AZEVEDO, ABUJAMRA and ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução*

[343] For an in-depth statistical analysis of reasoning in health care litigation judicial decisions, see ibid

participated in this research. They are, however, an important indicator of how, in relation to the judges interviewed in Brazil between 2016 and 2017, the legal and sociological factors interact when deciding about access to public health care.

That being said, the table below describes the keywords searched for in the decisions, and the "unique hits" counted by searching for it in the 700 documents. By unique hit, I mean how many decisions had at least one mention of the keyword. In relation to the number of interviews considered in this section (15) those account for the judge's whose judicial decisions could be found and accessed through the case law search in each court system. Therefore, the unique counts refer not to the total number of judges interviewed (19), but to those whose decisions were available and thus subject to the textual mining analysis (15).

Table 2: Number of Decisions Analysed per Interviewed Judge

Judge	Court (Degree Level)	Date Interview	Jurisdiction	Decisions analysed
1	Supreme Court	16/11/2016	Brasília	30
2	Supreme Court	17/11/2016	Brasília	70
3	Supreme Court	16/11/2016	Brasília	62
4	Supreme Court	28/02/2017	Brasília	72
5	Superior Court of Justice	17/11/2016	Brasília	60
6	Superior Court of Justice	24/11/2016	Brasília	60
7	Superior Court of Justice	28/02/2017	Brasília	0
8	Appellate Judge	03/02/2017	Santa Catarina	0
9	Appellate Judge	03/02/2017	Santa Catarina	0
10	Appellate Federal Judge	23/01/2017	Paraná	52
11	Fist-Degree Judge	09/12/2016	Rio de Janeiro	3
12	Fist-Degree Judge	09/12/2016	Rio de Janeiro	1
13	Fist-Degree Judge	23/11/2016	São Paulo	50
14	Fist-Degree Judge	03/12/2016	São Paulo	32
15	Appellate Judge	14/12/2016	São Paulo	36
16	Fist-Degree Judge	21/12/2016	São Paulo	0
17	Fist-Degree Judge	22/12/2016	São Paulo	50
18	Fist-Degree Judge	16/01/2017	São Paulo	100
19	First-Degree Federal Judge	22/01/2017	São Paulo	62
Total	-	-	-	700

Table 3: Text Mining Keywords Result

Keyword	Unique Counts in Decisions (Out of 700 Decisions)	Unique Counts in Interviews (Out of 15 Judges)
Article 196	611	3
Law N. 7.508[344]	11	0
Law N. 8080[345]	262	2
Agência Reguladora (Regulatory Agency)	5	2
ANVISA	175	15
Burocracia (Bureaucracy)	2	6
Confiança (Trust)	4	13
CONITEC	22	7
Corrupção (Corruption)	0	6
Custo (Cost)	343	10
Deferência (Deference)	25	5
Deputado (Congressperson)	2	3
Desconfiança (Distrust)	0	13
Direito Fundamental (Fundamental Right)	350	6
Ineficiência and inefficient (Inefficiency and inneficient)	45	10
Rename (National List of Drugs)	89	1
Renase (National List of Health Services)	10	0
Direito A Saúde (Right To Health care)	658	15
Separação Ou Tripartição Dos Poderes (Separation or Tripartition of Powers)	198	6
Direito A Vida (Right to Life)	232	14
Escassez (Scarcity)	25	5
Sofrimento (suffering)	131	11
Reserva do Possível (Reserve of Contingencies)	62	5
Impacto (Impact)	27	4

[344] Law 7508/11 regulates the CONITEC and the procedure for standardisation of the national medication and services lists, Renase and Rename.

[345] Law 8080/90 regulates the SUS.

As the table above indicates, there is a discrepancy between the topics brought up by judges during their interviews, such as trust, bureaucracy, and corruption (as analysed in chapters 3 and 4), and the main legal arguments used in the reasoning of their published decisions. In the next two sections I will explore what were the main arguments used in the published judicial decisions analysed (section 5.1), and subsequently which of the factors brought up during the interviews did not appear as part of the reasoning of the published judicial decisions analysed (section 5.2). Finally, in section 5.3 I analyse how these legal and sociological factors dialogue in the wider socio-legal phenomenon of health care litigation in Brazil. Particularly, I explore how this dialogue between the formal and informal justifications given by judges can be understood as a form of the *jeitinho*, which manouvers the constitutional law instrumentally to justify, in hindsight, decisions which are based on reasons such as distrust, empowerment, empathy, perceptions of corruption etc.

As said above, the exercise I undertake in this chapter does not aim to offer a separate quantitative finding, but to inform the main qualitative findings of this thesis, by offering insight into how the legal and sociological factors operate and interrelate within the judicial decisions to grant drugs, treatments and medical devices not covered by the public health system. As such, the terms used to mine the decisions of interviewed judges include both terms that were spontaneously mentioned by judges in their interviews and terms that were prompted by myself as the interviewer. For instance, as explained in chapters 1 and 4, distrust was not mentioned spontaneously by all judges, most judges used other terms that describe a context or phenomena closely related to distrust. I then questioned the judges if what they described resulted in or meant a lack of trust in the public health care system, which was then confirmed by most. Therefore, it could be expected that the published judicial decisions would not present words such as trust, distrust or even corruption. However, what I unpack in this chapter is how law serves as a hindsight instrument for decisions taken before the analysis of legal documents.

I also show through my data that the great majority of decisions mined in this chapter do not even refer to the themes mentioned in the interviews as central to the judge's decision to grant claims. For instance, the fact that the state is inefficient, corrupt or that there is a lack of political will to deliver better health services is totally absent from the great majority of decisions. Rather, judicial decisions are often short and limit the reasoning to the constitutional right to health provided for in article 196 of the 1988 Constitution, and the proven necessity of the drug, which is demonstrated by the claimant's medical prescription. As such, from the analysis of the legal documents, one could think that health care litigation was a simple legal issue, rather than a complex socio-legal phenomenon.

5.2 What are the main legal justifications found in the published judicial decisions?

In this first section I explore the legal arguments most used by the interviewed judges to justify their verdict to grant or deny access to drugs, treatment and/or medical devices not covered by the public system SUS. As it will be presented in this section, there are two core legal arguments used to justify granting access to the drugs and treatments not covered: (i) an extensive interpretation of the constitutional right to health care set out in the Brazilian Constitution in article 196, which was then enforced given (ii) the litigant's necessity to access the required drug, treatment or medical device, proven by the prescription issued by his/her medical doctor.

As it can be inferred by Table 3 above, the prevalent themes in published judicial decisions were 'article 196' (mentioned in 611/700 decisions), 'right to health' (mentioned in 658/700 decisions), 'right to life' (mentioned in 232/700 of decisions), 'fundamental right' (mentioned in 350/700 decisions) and 'cost' (mentioned in 343/100 decisions). These terms refer only to the analysis of the judicial decision (reasoning) and not to the arguments presented by the parties.

The five themes identified as central to the reasoning of judicial decisions (article 196, right to health, right to life, fundamental right and costs) were also mentioned by most judges during their interviews. However, the opposite is not true. Themes of high significance in interviews were mostly absent from the legal reasoning in the published judicial decisions. For example, trust and distrust were factors mentioned by 13/19 judges during their interviews as central to their decision-making. However, only 4/700 decisions refer to trust, and no decisions mentioned the term distrust. As said above, even though it could be expected that judicial decisions would not use wordings such as distrust or even corruption (outside a criminal case), the fact that the great majority of decisions do not discuss, even tangentially, the issues mentioned by judges themselves as central to their decision-making during the anonymised interviews can be an interesting indicator as to how the law is instrumental, but not central, to the judicial decisions in health care litigation in Brazil. My analysis suggests that judges manoeuvre the law in an instrumental way, and use it, with hindsight to justify decisions– a game played 'with the law' according to Silbey and Ewick[346]. By knowingly *using* the law to give a quick fix solution to the individual case, rather than addressing the systemic problem, judges are finding a *jeitinho* around the complex sociological problem.

In relation to the question of trust which is central to judge's decision to grant claims (discussed in chapter 4), from the 4 decisions which mentioned the terms explicitly, 3 referred to the trust placed by the plaintiff in his/her medical doctor. The argument, in all three occasions, is used to justify the importance of the medical prescription presented by the plaintiff as evidence to demonstrate the necessity of the requested drug, treatment or medical device – i.e., in opposition to the State's defence claim that such drug, treatment or medical

[346] EWICK and SILBEY, *The Commonplace of law. Stories of everyday Life*

device could be substituted by one included in the health care policy or was not the best treatment for the litigant. For example, in one of the decisions, the judge affirms that:

> [T]he relationship between doctor and patient is one based on *trust*, which is why the fact that the patient has received a prescription from a doctor for a certain medication, by itself, is sufficient to configure his/her interest in pleading it [in court]. The patient, with good reason, will never request a medicine different from the one recommended by his/her physician.[347]

The one decision in which trust was used in a different context, however, the judge did so to justify *denying* the medication to the plaintiff. The judge reasoned that the analysis of necessity for the requested drug depended on the opinion given by technical auxiliaries[348] of the court[349]. In such case, the judge did not solely rely on the argument of the plaintiff that the presentation of a doctor's prescription be sufficient to prove the necessity of the drug. Neither did (s)he rely on the administration's argument that the plaintiff did not need such medication, as (s)he could be treated with another drug already included in the health care policy of SUS. Rather, the judge relied on a third opinion from the medical committee (NAT-JUS), 'trusted by the court'. The committee understood, in that case, that the plaintiff had medical alternatives to the requested drug in the system. In light of that position, the judge denied the request for the drug[350].

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[347] REsp 1775384/CE, Herman Benjamin (2018) (Superior Court of Justice)

[348] In 2016, the National Council of Justice (CNJ) created the NAT-JUS (*núcleo de apoio técnico do Poder Judiciário*), a body of medical professionals who give impartial technical opinions on cases claiming access to health technologies. These bodies are not available in all courts, however.

[349] The adoption of such groups has reduced the rates of success in some States of the country, but are not yet adopted all throughout the country or by all judges when adjudicating cases (Katia Regina Tinoco Ribeiro de CASTRO, 'Os juízes diante da judicializção da saúde: o NAT como instrumento de aperfeiçoamento das decisões judiciais na área da saúde' 2012), (Maria Carolina Diógenes CAVALCANTI, 'Varas especializadas em matéria de saúde e núcleos de apoio técnico (nat-jus): contribuições para o judiciário na diminuição da judicialização ao acesso à saúde' (2018)).

[350] AI 5001262-91/RS, João Pedro Gebran Neto, Federal Court of Justice of the 4th Region (2013)

In the next sections I analyse further the prevalent topics used in the reasoning of published judicial decisions, and the topics absent from those documents. The question which I aim to answer by the end of this chapter is how these legal and sociological factors interact in the wider health care litigation phenomenon, and why this analysis is important in a wider discussion about formal law as justification for judges' decisions.

5.2.1 Constitutionalisation of rights: a tool enabling the expansion of judicial power

The transition of various countries[351] from authoritarian regimes to constitutional democracies from the 1980s to mid-2000s was accompanied by a trend of the constitutionalisation of right which Comaroff and Comaroff call an 'individual rights' fetishism'[352]. These new constitutions combined an extensive bill of rights with powerful instruments of judicial review. According to Tate and Vallinder, the justiciability of rights provided the institutional conditions for the judicialisation of politics[353] - an umbrella-like term which entails the 'reliance on courts and judicial means for addressing core moral predicaments, public policy questions and political controversies'[354].

Although some academics critically understand the constitutionalisation of rights as a political scheme to accommodate different group interests[355], the fact is that entrenching constitutions with individual and socio-economic rights enabled comprehensive changes in the

[351] Such trend was observed, for example, throughout Latin America, Africa and Eastern Europe (Ran HIRSCHL, "'Juristocracy" -- Political, not Juridical' (2004) 13 The Good Society 6)

[352] Jean COMAROFF and John COMAROFF, 'Law and disorder in the postcolony*' (2007) 15 Social Anthropology 133

[353] Neal C. TATE and Torjborn VALLINDER, *The Global Expansion of Judicial Power* (New York University Press 1995)

[354] Ran HIRSCHL, 'The Judicialization of Mega-Politics and the Rise of Political Courts' (2008) 11 Annual Review of Political Science 93

[355] For instance, on a critical assessment of Latin American constitutionalism:Roberto GARGARELLA, *Latin American constitutionalism, 1810-2010: the engine room of the Constitution* (Oxford University Press 2013)

access to such rights, especially in developing countries[356]. For instance, the constitutionalisation of the right to health care was a political victory of the 'sanitary movement' which enabled the creation of the unified health system, SUS[357].

Alongside the constitutionalisation of rights, the constitutional reforms also empowered judiciaries to guarantee the observation of the bill of rights, facilitate the participation of minorities and protect citizens against the tyranny of the majority[358]. However, what empirical observations have shown is that the access to court is often exercised by the wealthier, which would result in a counterproductive attempt of increasing equality, whilst widening gaps of inequality[359]. In the case of health care litigation in Brazil, Octavio Motta Ferraz has demonstrated such a trend through empirical analysis of the judicialisation demographics[360].

One characteristic of the literature analysis of constitutionalisation of rights is its focus on constitutional and supreme courts. However, in countries such as Brazil and Colombia, where judicial constitutional review can be undertaken *in concrete* analysis – i.e., in the context of a specific case – by lower court judges, then the constitutionalisation of rights needs to also be assessed from the bottom-up. This is the approach I take when analysing the increase of successful health care litigation in Brazil.

5.2.2 The aspirational Constitution: substantive constitutional law as a tool for judicial empowerment in Brazil

> We are not automatic robots, we have a Constitution, full of abstract values and antagonistic principles that we have to ponder. And it is not just my empathy that leads

[356] Bruce ACKERMAN, 'The Rise of World Constitutionalism' (1996) Occasional Papers

[357] FERRAZ, *Health as a Human Right: The Politics and Judicialisation of Health in Brazil*

[358] HIRSCHL, "'Juristocracy" -- Political, not Juridical'

[359] For instance: Russell G PEARCE, 'Redressing inequality in the market for justice: Why access to lawyers will never solve the problem and why rethinking the role of judges will help' (2004) 73 Fordham L Rev 969 and Sameena NAZIR, 'Challenging inequality: Obstacles and opportunities towards women's rights in the Middle East and North Africa' (2005) 5 JIJIS 31

[360] FERRAZ, 'Harming the poor through social rights litigation: lessons from Brazil'

> me to ponder in favour of the party that is sick. It is my reading of the Constitution. It is the recognition of the prevalence of the right to life, the right to health. If we had an effective, efficient State, perhaps there would be less judicialisation, perhaps the question would not arise[361].

The Brazilian Constitution was enacted in 1988 after the downfall of Brazil's military dictatorship, which ruled the country from 1964 to 1985. The 21-year period was marked by a harsh, totalitarian regime, in which many were tortured and killed[362]. The last years of the military ruling were distinct for its severe administration and harsh legal enactments, which obliterated most individual rights and freedoms[363].

In response to the dark period, the Brazilian constituents transformed the constitutional text into an extensive individual rights protection charter, which promised to shield citizens against any potential further act of tyranny coming from the State. Brazil is not the only country to have adopted strong constitutions after the downfall of authoritarian regimes. Similar constitutional movements are observed in other young democracies, such as Colombia, Argentina, India and South Africa, all of which incorporating an 'individual rights' fetishism'[364] in their new constitutional texts.

As the literature points out[365] this intention of the constituent to protect the citizens against the State through the 'rule of law' but to also repay the 'damages' suffered by individual citizens during the dictatorship by providing access to an 'upgraded' level of democracy. One which adhered to the second-generation of human rights and gave access to ample social and

[361] Interviewee 17 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

[362] Thomas E SKIDMORE, *The politics of military rule in Brazil, 1964-1985* (Oxford University Press, USA 1990)

[363] Wolfgang S HEINZ, 'The military, torture and human rights: Experiences from Argentina, Brazil, Chile and Uruguay', *The Politics of Pain* (Routledge 2019); Camila Maria Risso SALES and João Roberto MARTINS FILHO, 'The Economist and Human Rights Violations in Brazil During the Military Dictatorship' (2018) 40 Contexto Internacional 203

[364] COMAROFF and COMAROFF, 'Law and disorder in the postcolony*'

[365] Diana KAPISZEWSKI, 'Power Broker, Policy Maker, or Right Protector? The Brazilian Supremo Tribunal Federal in Transition ' in Gretchen Helme and Julio Ríos-Figueroa (eds), *Courts in Latin America* (Cambridge University Press 2011) 139.

economic rights. Thus, new constitutions, such as the Brazilian, incorporated not only a long list of negative, individual rights, protecting the individuals from the State, but also an extensive catalogue of duties to be fulfilled by the State.

This constitutionalisation of rights – including the right to health[366] - movement observed throughout young democracies in the 20th century[367] was indispensable for health care litigation to be possible in the first place. As a public defender of the state of Rio de Janeiro points out:

> Before, there was no judicialisation because, because the Constitution did not guarantee the right to health. We did not have a right to health that was positive and that gave the people subjective right to request a material health care provision. This did not exist, so of course there was no judicialisation. From the moment that we have health care as a positive right which citizens have knowledge of, they will search more and more [for its fulfilment] and litigation will start to be more frequent.[368]

Therefore, as a political response to the military dictatorship, and in an attempt to accommodate the interests of different political parties which participated of the constituent assembly[369], the Brazilian Constituent enacted a charter formed by an agglomerated of 250 articles which provide, amongst other things, for ample protection of first[370] and second-generation rights[371]. For example, the Constitution provides in article 6 that 'education, health,

[366] Matthew M KAVANAGH, 'Constitutionalizing Health: Rights, Democracy And The Political Economy Of Health Policy' (2017)

[367] Guilherme LEITE GONÇALVES and Sérgio COSTA, 'The global constitutionalization of human rights: Overcoming contemporary injustices or juridifying old asymmetries?' (2016) 64 Current Sociology 311 and Rett R LUDWIKOWSKI, 'Constitutionalization of Human Rights in Post-Soviet States and Latin America: A Comparative Analysis' (2004) 33 Ga J Int'l & Comp L 1

[368] Interviewee 21 (2016) Interview with public defender in Rio de Janeiro (RJ) [09/12/2016]

[369] GARGARELLA, *Too much "Old" in the "New" Latin American Constitutionalism*

[371] "The greater the breadth and vagueness of, and the more internally contradictory, the rights included in Constitution, the better the constitutional infrastructure for rights adjudication. Owing to the foreclosure of the judicial option for addressing the legacy of authoritarian rule and to Brazilian democrats' desire to shield the country from another experience with authoritarianism, the new charter – nicknamed the 'Citizen Constitution' (Constituição Cidadã) – contains extensive lists of rights. Title II enumerates a broad gamut of individual and collective rights and duties (Chapter I), and extensive series of social and economic rights (Chapter II as well as Title VIII), and multiple political rights (Chapter IV). Title III describes rights granted specifically to civil servants

food, work, housing, leisure, security, social security, protection of motherhood and childhood, and assistance to the destitute are social rights, as set forth by this Constitution'[372]. And further it states in article 196 that '[h]ealth is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery'.[373]

Therefore, in light of the excerpt from the Rio de Janeiro's public defender transcribed above, as an inherent legal phenomenon, access to health care via litigation would never been possible in the first place if the legislation – in this case, the Constitution – did not provide for the right to access health care as protected social right. In that sense, the Constitutional provision is a central legal factor in the health care litigation phenomenon.

However, the mere fact that the Brazilian Constitution provides for a universal access to health care does not necessarily mean that *all* Brazilian citizens are entitled to *any* medical device, drug or treatment – the 'right to everything'[374]. Such conclusion depends on the interpretation of what it means to have the Constitution determine that 'health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies (…)'. The majoritarian court interpretation, however, is that the right to health care is not programmatic but rather a justiciable, *individual* right, directly enforceable by courts:

> First of all, we have to understand that this judicialisation [of health care] has several causes. The first of them is the very fact that the Constitution of 88 and the statutory law opens the possibility [to judicialise the matter]. It first recognises health not only as a collective good, *but as an individual right*, which is integral part of a social minimum. Furthermore, it provides the procedural mechanisms, such as collective

(Chapter VII, Section II)." (KAPISZEWSKI, 'Power Broker, Policy Maker, or Right Protector? The Brazilian Supremo Tribunal Federal in Transition ')

[372] Article 6, Federal Constitution 1988, Brazil

[373] Article 196, Federal Constitution 1988, Brazil

[374] FERRAZ, *Health as a Human Right: The Politics and Judicialisation of Health in Brazil*

> action or individual litigation, as a legal arsenal that enable this type of action. The second reason is the fact that the 88 Constitution places great emphasis on the protection of the most vulnerable people. And this protection has been transferred to health care in a way[375].

The results from mining the 700 judicial decisions reafirm the qualitative finding that the constitutional right to health care, interpreted as an individual right "to everything", is the legal basis for successful health care claims. Moreover, 658/700 decisions analysed used the right to health care and article 196 as central arguments to justify granting the claims. Maybe even more importantly, only 262/700 decisions mentioned any statutory law (i.e., Law 8080/90 which regulates the SUS), 99 mentioned the state and federal health policy lists 'Rename' and 'Renase'[376], 22 mentioned the 'CONITEC' and 175 mentioned 'ANVISA'. This indicates how the judge, when deciding health care claims, is either not aware of the procedures and bodies involved in the definition of the health care policy, or disregards the statutory law directly applying the Constitution provision. According to a high civil servant of the Ministry of Health:

> I think there is a problem with the Brazilian legislation, particularly with the Constitution. At the time [the Constitution] was made, the constituents wanted it to provide for many rights. Even though the principles provided for in the Constitution are ample and require statutory legislation to regulate its application, the [Brazilian] *judge does not take the statute into account*. (…) To solve this we have two options, we either change the Constitution to expressly say that the SUS can only provide what is in the [public policy] list, which I think will not be done, which is what you are proposing to give, or the Supreme Court says what the limits [to health care litigation] are[377].

The extensive interpretation of the constitutional right to health care as an individual, justiciable right, leaves room for judges to grant drugs, treatments and medical devices even

[375] Interviewee 4 (2016) Interview with judge from the Superior Court of Justice in Brasília (DF) [17/11/2016]

[376] As explained in Chapter 1, the lists of drugs, treatments and medical devices offered by the public health care system, SUS, are defined by the competent bodies, such as CONITEC, in the federal, state and municipal levels. In the federal level, the two main lists as Rename (National List of Essential Medicines) and Renase (National Lists of Actions and Health Services).

[377] Interviewee 48 (2017) Interview with civil servant from CONITEC in Brasília (DF) [06/02/2017]

when those are not included in the public policy. Therefore, it is important to take a closer look at how this extensive interpretation takes place in the context of health care litigation.

5.2.3 The extensive interpretation of the constitutional right to health care as enabling an attenuated activism in health care litigation in Brazil

Interpretation is at the core of judicial activity. In very simple terms, when deciding cases, judges analyse the facts in light of the evidence presented by the parties and interpret the text of the law in order to apply it to the set of facts. Analysing the facts of a case is thus as important as the interpretation a judge gives to the legal text.

Interpretation is a task, a tool[378] and a power[379]. Cases which require the application of constitutional law often require the interpretation of vague provisions and principles, therefore conferring even more powers to the interpreters. For such reason academics and lawyers have profusely written about the different technics (or modes) of constitutional interpretation[380] and its consequences for the realisation of rights, for judicial activism and scope of judicial review[381]. Some of these discussions were briefly analysed in chapter 4, however, the objective of this chapter is not to discuss the theoretical basis of judicial interpretation or constitutional

[378] Morell E MULLINS SR, 'Tools, Not Rules: The Heuristic Nature of Statutory Interpretation' (2003) 30 J Legis 1

[379] Frank H EASTERBROOK, 'Legal Interpretation and the Power of the Judiciary' (1984) 7 Harv JL & Pub Pol'y 87

[380] Brandon J MURRILL, *Modes of Constitutional Interpretation* (2018); Mark TUSHNET, 'Justification in Constitutional Adjudication: A Comment on Constitutional Interpretation' (1993) 72 Tex L Rev 1707; Christopher WOLFE, *How to read the Constitution: originalism, constitutional interpretation, and judicial power* (Rowman & Littlefield 1996); Louis FISHER, 'Methods of Constitutional Interpretation: The Limits of Original Intent' (1987) 18 Cumb L Rev 43

[381] As an example of the different analysis of the consequences of constitutional interpretation in judicial decision-making: Gary LAWSON and Christopher D MOORE, 'The Executive Power of Constitutional Interpretation' (1995) 81 Iowa L Rev 1267; Robert F NAGEL, *Constitutional cultures: The mentality and consequences of judicial review* (Univ of California Press 1993); Martin EDELMAN, 'Written constitutions, democracy and judicial interpretation: the hobgoblin of judicial activism' (2004) 68 Alb L Rev 585

interpretation, but to understand how and why this theme is relevant to the case study of health care litigation in Brazil.

When analysing the published judicial decisions in claims seeking access to a drug or treatment not included in the health care public policy, the first and central argument is the constitutional right to universal health care. This is true for decisions on all levels of jurisdiction – from first degree to Supreme Court decisions. Not only does the article 196 of the Brazilian Constitution play a central role in the discussion, but it ultimately weighs in as the determinant factor to justify the positive outcome of litigation.

The core discussion of interpretation thus revolves around defining what the Brazilian constituent power intended when writing that '[h]ealth is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies (…)'? According to Ronald Dworkin[382], in interpreting the Constitution judges must make moral readings of the text, to show fidelity to the Constitution. In the case of health care litigation, the 'moral reading' judges make of article 196 is one which considers the expression' right of all' to mean that every Brazilian is entitled to a free and almost *limitless* health care which should be provided by the Brazilian State. Interestingly, the limit set by judges to what the Brazilian health care system is obliged to grant is not determined by the health policy maker, but by the judges own understanding of what is or is not reasonable according to the litigant's necessity – proven by the physician prescription.

This extensive interpretation of the Constitution found in most judicial decisions which grant the access to drugs and treatments not offered by the SUS. For example, in a case discussing the right to access the drug Ventavis, for treatment of a pulmonary arterial hypertension, the Superior Court of Justice rejected the State's defence alleging that the medication was not covered by the SUS' public policy and was experimental in nature, by

[382] Ronald DWORKIN, *A matter of principle* (OUP Oxford 1985)

affirming that the access to health care is a constitutional right and as such cannot be denied based on the lack of public policy provision:

> 1. Health is a fundamental right guaranteed to all citizens by the Constitution. Therefore, it is the duty of the State to guarantee the supply of medications necessary to maintain the health of the citizen.
> 2. Even though there is evidence that some of the drugs requested are not standardised [in the SUS' list of medications] or included in Clinical Protocols and the Therapeutics Guidelines, the jurisprudence has been widely stablished on the basis that the *mere lack of standardisation [in one of the SUS' lists] cannot serve as a reason in itself to justify not supplying medicines indispensable to the right to life of the patient*.
> 3. In the present case there is evidence in the prescription signed by the plaintiff's doctor, Dr. Angela Pontes Bandeira CRM-PE 8083 attesting to the necessity of the medication VENTAVIS (ILOPROST), whose supply demands the plaintiff (with pulmonary arterial hypertension). *This renders the conclusion that the use of this drug, in its the prescribed amount, is the most indicated for the treatment of the serious illness that afflicts the plaintiff, leaving no room for the State to argue that the medicine is experimental in character*.
> 4. It is the constitutional duty of the State to guarantee the health of the citizen.[383]

Even though the decision transcribed above states that the mere lack of standardisation (or inclusion in the health care policy's lists) is not enough to justify denying a citizen access to a medication, treatment or medical device, there is no established understanding of what would constitute reasonable grounds for its concession. Moreover, as discussed in the last Chapter 4, the judicial analysis of health care claims in mostly done in individual cases, and according to the individual judge's interpretation of the constitutional provision. The analysis of the decisions, and precedents from the Superior Court of Justice and Supreme Court of Justice, confirm such variation in what the *individual* judge and the courts understand to be a reasonable limit for concession of drugs, treatments and medical devices not covered by the health public policy. And, therefore, what are the practical boundaries of article 196 of the Brazilian Constitution.

[383] AgREsp 1383547/PE, Justice Mauro Campbell Marques, Superior Court of Justice (06/11/2018).

The fact is that the extensive interpretation of the Constitution according to each individual judge's discretion, allow for variations in the outcome of cases (i.e., whilst some judges grant experimental drugs, other do not, and some only in specific cases) which are influenced by the factors such as emotions[384], personal knowledge of medicine (due to a spouse[385] or close relative who is a medical doctor[386]), personal experience of illness[387] and use of alternative medicine[388], etc.

This lack of clearer boundaries for judicial interpretation of the constitutional right to health care, and limits to the judicial concession of drugs, treatments and medical was address by two important decisions from Brazilian Supreme Court in 2020[389], which aimed at setting some boundaries for the judicial concession of drugs, treatments and medical devices not approved by ANVISA. Through a binding precedent, the Court determined that experimental drugs and those not approved by ANVISA could not be granted by judges, unless the Agency had unreasonably delayed the analysis of the drug or/and the drug has been approved by respected agencies in other jurisdictions, such as the FDA/USA.

It is worth mentioning that the abovementioned decision is recent – dating from March 2020, and albeit an important step to curb the raise of successful health care claims in cases of drugs not approved by ANVISA, it still do not offer wider limits or standards to exercise of judicial review in Brazil. It is yet to be seen how these decisions will be applied in lower courts, if it will curb litigation of experimental drugs or not approved by ANVISA. There is still no data about the impact of such decision in the numbers of health care litigation.

[384] Interviewee 16 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

[385] Interviewee 14 (2016) Interview with first degree judge in (SP) [03/12/2016]

[386] Interviewee 11 (2016) Interview with first degree judge in Araraquara (SP) [23/11/2016]

[387] Interviewee 24 (2016) Interview with appellate judge in São Paulo (SP) [14/12/2016]

[388] Interviewee 38 (2017) Interview with first-degree federal judge from São Paulo (SP) [22/01/2017]

[389] RE 566471/RN, Min. Marco Aurélio Mello, Brazilian Supreme Court (2020)

Irrespective of the variations of limit set by different judges in Brazil to the interpretation of article 196 of the Constitution, the importance here is to understand how the substantive constitutional law is *manoeuvred* by judges as a means to justify a decision that is not *purely* legal. The extensive interpretation of the constitutional command gives space to the manifestation of the sociological factors discussed in chapters 3 and 4 as concealed motives, which have bearing on the outcome of the case according to my interviews. In this regard, I suggest that substantial constitutional law serves as a hindsight justification and a constitutional *veil* for the distrust in the Executive and the activism of Brazilian judges. [390]

The instrumental manoeuvring of the substantive constitutional law as a justification for granting health care claims – particularly *vis a vis* other socio-economic rights provisions in the Constitution that are not used in the same manner - serves therefore as a *jeitinho.* By giving extensive application to the *universal and integral right to health care* provided for in article 196 and 198, II, of the Constitution, Brazilian judges are able work *around – or with - the law* in order to compensate for political and social problems - such as the perceived inefficient and corrupt State – ultimately enabling a perceived social justice by helping someone who they empathise with. According to a public defender from Rio de Janeiro:

> I think that considering the situation of vulnerability that many people find themselves in, and that the extra-legal factors, outside the law, the judge grants the claim. (…) But most time judicial decisions are based just on [constitutional] principles, so you realize that [through the use of substantive constitutional law] the judge can justify any decision. And you realise that, unfortunately, we lack a more robust legal argument[391]

[390] For example, according to Gillman: 'Spaeth and Segal (1993,363) have suggested in the past that any post hoc interpretation of law's influence amounts to mere "normative rationalization" that "masks the reality of choice based on the individual justices' personal policy preferences." But none of the studies referred to above were written by judges or law professors with an interest in disguising the actual motivation of judges. All were written by scholars who were mindful of the debates in the literature about legal versus personal influences on decision making, and all attempted to show how the judges' expressed beliefs and patterns of behaviour could only be explained with reference to distinctive legal norms (Howard GILLMAN, 'What's law got to do with it? Judicial behavioralists test the "legal model" of judicial decision making' (2001) 26 Law & Social Inquiry 465)

[391] Interviewee 21 (2016) Interview with public defender in Rio de Janeiro (RJ) [09/12/2016]

By saying that judicial decisions lack a more robust legal argument the public defender refers to analysis that would go beyond the application of the constitutional law – i.e., analysing the application of the statutory law, such as Law 8.080/90, the health authorities' acts, such as Anisa or CONITEC decisions, and the impact on the public budget. In the words of a first-degree judge from Campinas:

> The reasoning of the judicial decisions, in the case of health care access, does not to discuss public policy. It protects the fundamental individual right of the party. If the party has a right that has been violated, (s)he has a right to redress. It is a subjective right, which must be protected. The legal argument in these cases is based on the fundamental right to health care, which derives from the vertical relationship between the member of society and the State. So, this is the legal reasoning, it doesn't talk about public policy. It is grounded on the fundamental right [to health care], article fifth and article 196 of the Federal Constitution[392].

The State defence includes arguments about the limitation of the public budget to absorb drugs, treatments and medical devices not included in the public policy, and the need to observe the cost-efficiency analysis performed by the technical bodies as provided for in the article 19-O of Law 8080/90[393]. This argument suggests the application of the *precondition of possibility* theory (*Vorbehalt des Möglichen)*[394], which limits the realisation of a right according to the possibilities/constraints of the public budget. However, these arguments are dismissed by judges by contrasting the relevance of the fundamental right to health care and

[392] Interviewee 32 (2017) Interview with first-degree judge in Campinas (SP) [16/01/2017]

[393] 'In any case, the drugs or products referred to by the caput of this article will be evaluated for their efficacy, safety, effectiveness and cost-effectiveness for the different evolutionary stages of the disease or health problem dealt with in the protocol' (Article 19-O, *paragrafo unico*, Law 8.080/1990, Brazil)

[394] The theory of the precondition of possibilities (Vorbehalt des Möglichen) was developed in the 1972 decision of the German Constitutional Court (Bundesverfassungsgericht) in the case "*numerus clausus I*" (BVerfGE 33, 303) which analysed the request of a group of students who were denied vacancies in public medical school. The students claimed that by denying a place in the medical school the State would be violating the article 12(1) of the Basic Law, which provides that 'all Germans shall have the right freely to choose their occupation or profession, their place of work and their place of training'. The German Court understood that according to the theory of the precondition of possibility, the allocation of a large portion of public resources to meet an individual request would offend the protection of the common good, and that universities were allowed to apply objective limits to student selection, as long as those were within *reasonable* limits. The application of the novel theory gave rise to the application of a reasonableness tests in judicial review lawsuits against the German State.

right to life, protected by the Constitution, to a "mere" budgetary limitation. In a paradigmatic decision which analysed the application of the precondition of possibility to judicial review cases against the State, the Supreme Court decided that:

> In principle, the Judiciary should not intervene in a sphere reserved for another power, replacing its judgments of convenience and opportunity (…). However, *it seems to us increasingly necessary to review of the old dogma of the Separation of Powers* in relation to control of public expenditure and the provision of basic services within the Welfare State, since the Legislative and Executive powers in Brazil proved unable to guarantee a rational fulfilment of their respective constitutional obligations. The effectiveness of Fundamental Social Rights and its material realisation depends, of course, of the public resources available; there is usually a constitutional delegation for the legislator to materialise the content of these rights. Many authors believe that it would be illegitimate for the Judicial power to exercise control of such decisions, due to a violation of the principle of Separation of Powers (...). Many authors and judges do not accept, until this today, that the State holds the obligation of providing directly to each individual citizen the required care, medical, education, housing or food. Neither the doctrine nor the jurisprudence have understood the scope of the programmatic constitutional norms on social rights, nor given them adequate application as principle-requisite of social justice. The denial [by the State] to fulfil any kind of obligation related to Fundamental Social Rights has the consequence of renouncing such as true rights. (...) In general, there is increase in the group of those who consider the constitutional principles and substantive constitutional law as direct sources of law and obligation, and who admit the judicial intervention in cases of unconstitutional omissions.[395]

This precedent is recurrently used by judges to dismiss the State's argument regarding limitations to the public budget, and the *precondition of possibility* theory. In another case in which the Supreme Court analysed the request for access to a drug not included in the SUS's protocols the rapporteur Justice understood that:

> 1. As stipulated in article 196 of the Federal Charter, it constitutes a duty of the State to provide health care, ensuring the reduction of disease risk, implementing actions and services for the promotion of health care. The State (…) must be equipped in order to fulfil the unrestricted observance of the constitutional provision and *is not appropriate to quibble by excuses related to cash deficiency***.** The immense tax load supported by Brazilians impeded this eternal same old excuse.[396]

[395] ADPF 45/DF, Min. Celso de Mello, Brazilian Supreme Court (4/05/2004)

[396] AgReg RE 744.170/RJ, Min. Marco Aurélio, Brazilian Supreme Court (26/11/2013)

Accordingly, the Superior Court of Justice decided that:

> The absence of the drug requested by the plaintiff in the list drawn up by the Ministry of Health or by the State Secretary of Health does not prevent the State from having to supply a prescribed medication to patients with severe illness. (…) The right to health a life, constitutionally guaranteed, prevails over any administrative norms and budgetary interests of the federative entity.[397]

It is worth noting that most of these cases, including the two cited above were decided before the 2020 decision of the Supreme Court limiting the granting of access to drugs and treatments not approved by ANVISA.

According to a State's attorney interviewed in São Paulo[398], the reiterated rejection by judges of the State's argument on limitation of the public budget, led the State Attorney's Office to drop the argument in all lawsuits requesting drugs and treatments not covered by the public system. According to him/her, any of the legal arguments presented by the State which alleged that the lawsuit would be in breach of the separation of powers or that it would overburden the public budget, were immediately rejected by judges and courts on the basis that the constitutional right to health and life cannot be limited by such boundaries.

The extensive interpretation of the constitutional law as a trumping card against any sort of limitation to the access of health care is also reflected on the themes and arguments *not* considered in the judicial decisions. Furthermore, I suggest that the constitutional law serves, as said before, as a hindsight justification for the judicial decisions which are also influenced by sociological factors not discussed in the reasoning. Although the different nature of the two mediums where judges talk about and justify their decision-making process – anonymous interviews and formal, published legal decisions – are expected to be translated into distinct

[397] AI 1191156/MT, Min. Mauro Campbell Marques, Superior Court of Justice (16/09/2009)

[398] Interviewee 36 (2017) Interview with public attorney for the state of São Paulo (SP) [18/01/2017]

linguistic forms[399], I draw attention to how the great majority of the published judicial decisions mined in this chapter do not even refer to the topics judges themselves indicate as central to their decision-making process during the interviews. Furthermore, I also draw attention to an important legal framework which is also strikingly absent from these judicial decisions – such as the statutory law that regulates the public health system. Both the discrepancy between the formal legal justification and the sociological factors raised by judges in their interviews, and the way the use of the law (including in its omissions) dialogues with the sociological factors, is important to give a wider socio-legal understanding of the health care litigation phenomenon, which is what I analyse next.

5.3 What is absent from published judicial decisions?

> I have no doubt that all this corruption portrayed in the media, this troubled political moment that we are going through, all of this influences the judge's decision. I have no doubt. There is a difference between legal reasoning and motivation, you know. This [corruption] does not appear in their reasoning, of course, but their motivation, if you ask them…[400]

It can be easily concluded from Table 3 that the sociological factors identified by the interviews as influencing judges' decision-making are absent from the published judicial decisions. In this regard I mined the 700 decisions searching for 5 themes central to the sociolegal explanations given by judges during interviews: trust, corruption, distrust, inefficiency and bureaucracy (referring, for example, to an inefficient or inadequate bureaucracy in the Executive's policy making). The result shows how the themes do not bear

[399] In 'Language in the Legal Process', Brenda Danet analyses the centrality of words to law, and how in its entirely symbolic and abstract nature, the fact that 'words count', or matter, make 'serious' language critical to the function of the law. According to Danet, legal language creates 'the illusion of certainty in a world of uncertainty' (p. 545) and, by 'thickening' the language, legal texts are 'precise only when it is in the draftsperson's interest to be precise' (Brenda DANET, 'Language in the legal process' (1979) 14 LAw & Soc'y REv 445, p. 541).

[400] Interviewee 13 (2016) Interview with private attorney specialised in health law in São Paulo (SP) [24/11/2016]

the same importance in the reasoning of judicial decisions. For example, trust, central themes to the interviews, were mentioned in 13/15 of interviews and 4/700 decisions, whilst inefficiency was mentioned by 10/15 interviews and 10/700 decisions, corruption was mentioned by 6/15 interviews and 0/700 decisions and (problems in the) bureaucracy was brought up by 6/15 judges and 2/700 decisions.

The question which can be raised from the disconnection between the legal and the sociological justifications is: what purpose does the formal law serve in the solution of social conflicts, when it is used in hindsight decisions taken in light of other sociological factors? I address these questions from a sociological perspective of the Brazilian context in section 5.3 below.

Beyond the sociological factors, the findings from the textual analysis of the 700 published decisions undertaken in this chapter identified other legal themes which are *not* taken into consideration in the reasoning of published judicial decisions. These themes are represented by the keywords: ANVISA, CONITEC, 8080[401], 7508[402], Rename[403] and Renase[404].

These findings presented in Table 3 confirm the result obtained by a robust quantitative research conducted by Insper and the National Justice Council in 2018[405]. On that research, the textual mining of over 20 million published judicial decisions showed that only 1.2% of decisions mentioned the term ANVISA – of which ANVISA was mentioned in 26% of

[401] Law 8090/90 regulates the public health care system, SUS.

[402] Decree 7508/11 regulates the process for definition of the national lists of drugs and treatments offered by SUS – Rename and Renase.

[403] Rename (Relação Nacional de Medicamentos Essenciais) is the national list of drugs included in the public health care system, SUS.

[404] Renase (Relação Nacional de Ações e Serviços de Saúde) is the national list of treatments and services included in the public health care system, SUS.

[405] DE AZEVEDO, ABUJAMRA and ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução*

decisions to extinguish the lawsuits, 3% of decisions denying the request completely, and 7.52% of decisions denying partially. In relation to CONITEC, only 0.7% of decisions mentioned the term. Following similar pattern as ANVISA, a higher percentage of decisions which mentioned the Council did so to justify the decision to deny the request for access to a drug or treatment.

As shown in Table 3, although CONITEC is mentioned by 7/15 judges during their interviews, only 22/700 of decisions refer to the term. Interestingly, all of those 22 decisions were granted by 5 judges, who happened to be part of working groups about health care litigation in the National Council of Justice or/and their local courts. These working groups, called Health Forum (*Fórum da Saúde*), are initiatives of the National Council of Justice to raise awareness about the health care policy to judges, and bridge the gap between policy makers and adjudicators. In doing so, the Forum seeks to increase trust between the Judiciary and Executive, and as a consequence reduce the number of successful litigations against the State.

Accordingly, to an interviewed judge from São Paulo, the lack of knowledge about the public policy feeds into judge's distrust of the health policy decision-making system:

> [T]he judge is someone who has learned legal rules and a series of judicial precedents. (…) So, do not expect that a judge will know about the procedures for approval of a drug at ANVISA, or to know about the requirements of a laboratory test phase. They don't know, and they don't want to know.[406]

Another first-degree judge from Rio de Janeiro confirms the same perception. According to him/her:

[406] Interviewee 27 (2016) Interview with first-degree judge in São Paulo (SP) [22/12/2016]

> I don't know if drugs for hepatitis, for example, are registered [in the SUS]. It is not my job to know. What I know is that there are countless people who desperately need treatment for hepatitis, treatment for diabetes…[407]

Even a civil servant from ANVISA expressly affirmed not knowing if the CONITEC was a body of SUS[408]. Therefore, the results revealed in the textual analysis of the interviewed judges' published judicial decisions which shows a lack of mentions to CONITEC and other themes directly related to the health care policy, strengthen the argument that judges in Brazil lack basic technical knowledge about the public health care system. This then feeds into a distrust and lack of deference for the technical bodies which constitute the public health care system, SUS - such as ANVISA and CONITEC. Contrariwise, judges who have closer contact with the policy maker, and especially those who meet professionals from CONITEC and ANVISA, portray, both in their published decisions and during their interviews, higher deferential attitude towards the public policy in relation to the other judges. In the words of a federal judge from São Paulo:

> Another issue is a lack of transparency of the State's policy, the lack of transparency about the policies, because if I had a real knowledge of how the Executive works, how the SUS works, I would decide differently. (…) This lack of knowledge about the SUS, leads to an increased judicialisation. And the lack of interinstitutional dialogue is critical in Brazil. We lack a lot of inter-institutional and intra-institutional dialogue, so for many judges talking to the Executive may seem like you are losing impartiality or even power, when in my opinion we would be better informed in doing so.[409]

In the concrete control of constitutionality – such as the cases of health care litigation, the abstract interpretation of the constitutional law is not sufficient, however. It is necessary for the plaintiff to demonstrate that there was an actual infringement of a constitutional right.

[407] Interviewee 17 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

[408] Interviewee 54 (2017) Interview with public lawyer for ANVISA in Brasília (DF) [07/06/2017]

[409] Interviewee 38 (2017) Interview with first-degree federal judge from São Paulo (SP) [22/01/2017]

This is done by proving that the administration denied the realisation of the right to health by not providing a drug or treatment which the plaintiff needed in order to enjoy his/her right completely. Moreover, alongside the relevance of the substantive constitutional law, another important legal factor is the burden of proof required by judges to justify the concession of drugs and treatments not included in the health care system.

5.4 Burden of proof: reliance on the medical prescription

> Between deciding not to grant [the treatment] because it *could* disrupt the public [health care] system, or because it *could* be a case involving bad faith or fraud... Between the *if* and the concrete evidence (s)he has before her/him, (s)he decides to grant access to the treatment. Especially because, and now let's talk about law, it's in the Constitution. *If the doctor* prescribed *it, I will grant it*. (…) It is not that the judges are carelessness, or that we are being activists - judicial activism would be something else, it would be legislating where the legislator omits. In these cases, the judge received an urgent request. (…) So, why do we give the injunctions? Honestly because there is no other way, because between saying yes or no, although we have a series of doubts at the initial stages of litigation, when a health issue is at stake and we are talking about a fundamental right, the judge will always choose to grant it.[410]

In the sections above I argued that the extensive interpretation of the constitutional right to health care awards litigants with an immediate justiciable right to enforcement it against the State. However, in order to claim the right, the right-bearer must prove its necessity. Here is where the burden of proof in health care judicial review cases becomes relevant. Once the litigant proves the necessity of a health care provision, his/her abstract constitutional right is materialised, thus creating in the State an obligation to fulfil it.

In the case of individual claims seeking access to public health care in Brazil, the 700 mined decisions analysed and the interviews with judges and lawyer, indicate that the mere presentation of a medical prescription suffices to fulfil the burden of proof. According to a private attorney from São Paulo, who is specialised in health care law:

[410] Interviewee 11 (2016) Interview with first degree judge in Araraquara (SP) [23/11/2016]

> A judge does not take a decision from his head. He *trusts* the medical doctor. He says: according to the doctor's report, found in pages such and such, I grant the request… And if tomorrow or the next day (s)he is questioned about his/her decision, the judge can say: 'hey, don't blame it on me, I did what the doctor asked me to do. The doctor said that this medicine was necessary for the maintenance of this person's life, and so I, following the highest [constitutional] right to life, decided according to what the prescription signed by the doctor said. The judge knows that (s)he has power to decide, but this decision lies a lot in his/her trust in the medical doctor[411].

According to the quote from the private attorney, there are two factors influencing the judge's analysis of the evidence presented by the litigant: one relates to the judge's deference to the medical professional. A trust of the medical professional, and the transference of responsibility for the outcome of the decision in the hands of the doctor. By attributing the burden of proof entirely in the medical prescription, the judge is exempting him/herself from the responsibility of an unwanted health outcome and justifying the need against an alleged lack of public resources. In the words of a first-degree judge from Rio de Janeiro:

> The doctor is the strong part of this whole process [of increase in successful health care litigation]. There is a health problem, which is tackled by the doctor, and there is a legal problem, resolved by the judge. The one who creates a founded or unfounded expectation in the party – which is what we judge have to deal in end - is the medical doctor.[412]

The Supreme Court's decision[413] of 2020 mentioned before also addresses the reliance on the medical prescription, by requiring that the prescriptions be signed by a medical doctor from the public health system, SUS – limiting thus the possibility of a private doctor who does not practice in public hospitals to prescribe a drug or treatment not included in the public policy.

[411] Interviewee 33 (2017) Interview with private attorney specialised in health care law in Rio de Janeiro [25/02/2017]

[412] Interviewee 16 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

[413] RE 657178/MG, Min. Marco Aurélio Mello, Brazilian Supreme Court [11/03/2020]

It remains to be seen the extent to which such limitations will translate into reductions in the number of successful health care claims against the Brazilian State.

> [The] judicialisation [of health care] is widespread in Brazil, and there is no greater control by the Judiciary in evaluating the medical prescriptions, because the Brazilian Judiciary respects the health professional. (S)he thinks that if the doctor prescribed, that's it. (S)he will not question it. This is why so many products without ANVISA's registration are thrown in the national market through litigation[414].

While on the one hand, judges tend to trust the evidence presented by litigants, based on their personal doctor's prescription, on the other hand, they distrust the evidence presented by the State's defence. Moreover, according to judges and State attorneys, the defence's allegations and evidence of budget limitation are not sufficient to convince judges about the State's incapacity to provide *any* drug, treatment or medical device. Furthermore, the State's defence argument suggesting an alternative treatment (included in the public policy), in accordance with the opinion of technical bodies are often rejected with the justification that the litigant's doctor is the best person to decide about the litigant's health state. In the words of a first-degree judge from Rio de Janeiro:

> To begin with, we are dealing with a constitutional right to life. So, any consideration I make has to be in favour of the health and life of the person behind that lawsuit. Of course, we consider the cost of the medication, we understand the insufficiency of public resources. However, I have never decided a case in which this insufficiency of resources was adequately proven by the State. It is always presented as a generic argument. I have never seen concrete data on the public budget. (…) *The argument of insufficient resources has been presented so many times by the State's defence that I have for a long time now decided not to consider it in my reasoning*, as it is emptied of any specification, it was a generic argument. The argument of insufficiency of resources can be used for anything… and it annoys me more than anything![415]

[414] Interviewee 11 (2016) Interview with first degree judge in Araraquara (SP) [23/11/2016]

[415] Interviewee 17 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

The double standard offered by judges to the arguments and evidence presented by the litigant *vis a vis* the ones presented by the State's defence is intimately related to the judge's generalised distrust in the public administration and his/her altruism towards litigants. This distrust is then justified in legal arguments (i.e., as mentioned by the judge above, the lack of adequate evidence). The use of the substantive constitutional law and the procedural law serve as a way around the perceived problems of the health care system – a *jeitinho* which formalises the informal.

5.5 Formal legal justification versus the informality of the *jeitinho*: using the law in hindsight

The interaction between the manoeuvering of the substantive constitutional law used to support the *ratio decidendi* of the published judicial decisions and the sociological factors brought up during the interviews can be understood as another expression of the *jeitinho brasileiro* explained in Chapter 2. Moreover, by using a constitutional provision in order to justify granting health care claims in the formal decisions, whilst indicating during the interviews that such interpretation of the constitution might not be used in other cases, and intentionally omitting other relevant legal provisions (such as the statutory law that regulates the SUS), not fully addressing the State's defence arguments or dealing with issues central to their personal decision-making processes (such as perceptions of inefficiency or corruption) – the judges find a *jeitinho* around and within the law to achieve their objectives and grant the requests for drugs, treatments and medical devices. Furthermore, by not addressing in the legal decisions the systemic issues they themselves point out in their interviews and by turning a blind eye to the known consequences of mass health care litigation, such as inefficiency in the use of public resources for SUS and inequity, judges are also finding a *jeitinho* to address the individual problems of their localities (districts) whilst turning a blind eye to the systemic and

collective consequences of their decisions. For some, this is a necessary evil, for others it is a way to perpetuate inequality and feed into a systemic inefficiency.

In a country where politicians, Executive and public bodies are perceived to be corrupt and inefficient, and the access to basic public service in health, education and sanitation, is extremely unequal, judicial intervention is understood by many – including judges themselves - as the only alternative. The use of the constitutional legal discourse as hindsight justification offers a coat of legitimation to this complex sociological and personal decisions. Factors such as altruism, personal empowerment, distrust, all of which central to the decision-making process of a judge who will grant or deny the concession of a drug, treatment or medical device not included in the public system, are concealed from the legal debate and the published decisions.

The preponderance of the substantive constitutional right to justify individual solutions are a *jeitinho* around social problems which are too difficult to solve. And in such a way Constitutional law is a central factor influencing the increase of successful health care litigation in Brazil. It is the legal behind the socio-legal. But not because it is at the root of judges' decisions, but because it is a way around the omission of politicians, the corruption, the legacy of colonialism. It is a way to formalise the informal.

The *jeitinho* helps to deal with the discrepancy between the "real Brazil" and the theatre of law, where formal discourses and procedures mask a reality which is concealed. A modern iteration of the story of Brazil written by the German Martius, according to which Brazil was a country without racism or social struggles (the tale of the rivers told in Chapter 2). In very rare occasions the published judicial decision talk about the real problems behind health care litigation.

The structural inequalities present in the Brazilian society make it impossible for the marginalised and the less privileged part of society to fully exercise their rights (including

litigate their right to health care as Octavio Motta Ferraz suggests[416]). However, in the substantive constitutional law all Brazilians are equal and entitled to the same net of social rights, which the Brazilian State is unable to fulfil. As the patrimonial, unequal reality in Brazil lives on, creating an infinite discrepancy between the quality of services enjoyed by the elites and those of the rest of society, there is no easy solution. So, a way around it, a *jeitinho*, is to give to those who ask. And to do so, the formal law and the power of the pen provide the shortcut needed.

These different dimensions of the phenomenon and the nuances of perceptions highlighted in the interviews also reflect the multiple facets of the *jeitinho* . On the one hand, some interviewees described health care litigation as 'solution' to a systemic health care problem – even if a temporary or patchy one; a quick fix. This view of health care litigation could be framed as a form of creative *jeitinho*. One which is used to circumvent and cope with a draconian system. On the other hand, other interviewees described the health care litigation as a 'clever dodge', sometimes unethical, which creates shortcuts that are only accessible to a restricted part of the population that can make use of the legal system, and as such widens inequalities, and that incentivises an unethical use of the judicial system for the profit of the pharmaceutical industry and sometimes fraudulent schemes (described in Chapter 7).

5.6 Conclusion: what has law got to do with it?

Through the analysis of published judicial decisions in health care litigation in Brazil, one might think that the outcome is the result of a simple equation: necessity (proven by the medical prescription) + Constitutional right to health care (article 196) = concession of the drug

[416] FERRAZ, *Health as a Human Right: The Politics and Judicialisation of Health in Brazil*

or treatment requested. However, as explored in chapters 3 and 4 of this thesis, there are many other sociological factors which are central to the outcome of the legal disputes.

Through the textual analysis of 700 published judicial decisions by judges whom I interviewed in Brazil I informed the qualitative findings of this thesis by illustrating how the the formal law, and particularly the substantial constitutional rights, links to the other sociological factors, and which role it plays in the health care phenomenon. My argument is that the substantive constitutional law serves as a legal justification in hindsight – and sometimes a veil - to the decisions, which in turn are influenced by several other sociological factors, such as distrust, altruism and self-empowerment.

Therefore, the analysis of legal decisions in a vacuum can only tell part of the story that is litigation for health care access. The context about where and under what political and sociological circumstances these decisions were taken is essential to understand a full picture of the phenomena. Only by understanding both legal and sociological factors can one draw the full picture of health care in each jurisdiction. In the next chapter I look at the socio-legal factors influencing litigant's choice to start legal action for access to health care.

CHAPTER 6 - WHY DO [SO MANY] BRAZILIANS SUE THE STATE? AN ANALYSIS OF UTILITARIANISM AND THE COMMODIFICATION OF LITIGATION FOR ACCESS TO HEALTH CARE

Espera. Uma fila enorme se forma todas as manhãs na defensoria com pessoas em busca de Justiça gratuita **417**

Caption: 'Delay. A long queue forms every morning in front of the public defender's office of citizens in search of legal aid'

> [T]he judicialisation fever does not take place only in health care. It is in all areas [of social and economic rights in Brazil]. [The information about winning a lawsuit against the State] spreads from one person to the next and becomes a culture. [Litigating] becomes a convenience. (…) From 2003 until 2010, so for 7 or 8 years, we did not have any new incorporation [to the public health care policy], no new technology. So, patients' associations started, some of them influenced by the [pharmaceutical] industry, seeking justice. This became a snowball, because the increase in litigation is geometric, not arithmetic: one litigant tells other two people, who then tell four, who then tell eight, and so on. This creates a whole movement that works under the logic: 'let us go to the Judiciary, because it is via litigation that we get access to things.' Today, people file lawsuits to ask for milk, to ask for Viagra, to ask for diapers.[418]

[417] Source: https://www.otempo.com.br/cidades/pensao-responde-por-90-dos-processos-na-vara-da-familia-1.1317584

[418] Interviewee 41 (2017) Interview with representative of a pharmaceutical company in São Paulo (SP) [26/01/2017]

The excerpt transcribed above is part of the interview conducted with the president of an association (NGO) which represents the interest of rare disease patients in Brazil[419]. It depicts his/her answer when asked what (s)he thought explained the increase of successful health care claims in Brazil. Before going into details about the health care litigation specifically, the interviewee starts by describing a larger cultural phenomenon which (s)he calls the *litigation fever*. According to him/her, this fever refers to how Brazilians often resort to courts to solve all sorts of individual issues and collective grievances, from neighbour fights to access to social-economic rights. But why do Brazilians so often resort to legal action?

There is no simple answer to this question, and it is not my intention in this thesis to give an exhaustive explanation to this complex issue, which is comprised of both legal and sociological factors[420]. However, from my original, qualitative in-depth case study of health care litigation, I am able to give some accounts of the socio-legal factors that contribute to understanding why this litigation fever[421] in Brazil takes place and why it has such individualistic contours.

In Chapters 3 to 5 I focused on understanding the factors influencing judge's decision to grant health care claims. In this chapter I analyse the factors influencing litigants' decision to start legal action. As I will explain, the decision-making process of both actors (judges and litigants) are intimately connected, insofar as the (repetitive) decision of judges to grant these claims generates in litigants an expectation of successfully accessing drugs, treatments and medical devices via litigation. This expectation, which I frame as a *utilitarian trust in the*

[419]Interviewee 10 (2016) Interview representative of a patient's association in São Paulo (SP) [23/11/2016].

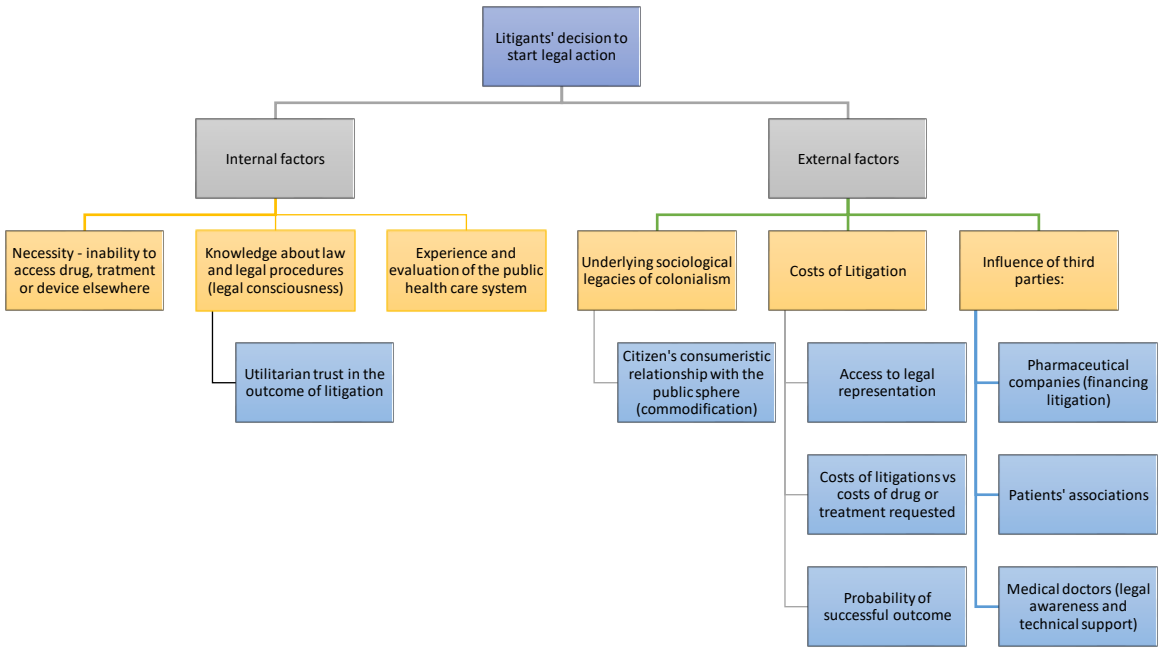
[420] By extra-legal I refer to a broad range of contextual factors not governed by law, like for example cultural factors, psychological factors etc. For example, the research on conflict resolution and culture traces an interesting perspective of how different cultures deal with conflict resolution or crime punishment (on the topic David GARLAND, *Punishment and modern society: A study in social theory* (University of Chicago Press 2012))

[421] David WOODS, 'Litigation fever' (1986) 134 CMAJ: Canadian Medical Association Journal 1103

Judiciary (explained in Section 6.4 below), is reinforced by other internal and external factors, also examined throughout this chapter.

The diagram below analytically identifies the key internal and external factors influencing litigants' decision to start legal action.

FIGURE 7: SOCIO-LEGAL FACTORS THAT INFLUENCE LITIGANTS' DECISION TO START A LEGAL CLAIM



First, I start by explaining the structural framework of a "litigation fever"[422] – as referred to by the literature and described by the NGO representative above – which encompasses legal and institutional structures that allow for easy, cheap access to courts (section 6.1). Then, in section 6.2, I address the commodification of health care and access to

[422] Ibid, and Patricia W Hatamyar MOORE, 'The civil caseload of the federal district courts' (2015) U Ill L Rev 1177

justice as a structural framework where citizens behave as clients or consumers of public services, a quid pro quo equilibrium around systemic problems. Within that context, I then analyse how individual litigants describe deciding to start legal action, focusing on the calculating nature of their decisions (costs of litigation *vis a vis* cost of the health devices) in section 6.3, and a utilitarian trust in the Judiciary in section 6.4. Finally, in section 6.5, by analysing how litigants' frame their understanding of the right to health care, I assess their 'legal consciousness' and discuss if and to what degree their decision to start legal action against the State for access to health care is an expression of their citizenship in a post-colonial context. The role of the third parties as factors influencing the rise of mass litigation in Brazil is the subject of Chapter 7.

6.1. A litigation fever: the constitutional right to a day in court as an external factor influencing the massification of health care litigation in Brazil

Part of the literature attributes the general increase of litigation in Brazil to the wave of privatisations undertaken during the 90s[423] - and the subsequent lawsuits filed to contest it. Others attribute it to events such as President Collor's economic reforms[424], which took thousands to courts in the early 90s. Both waves happen in the aftermath of the 1985 process of transition from the military dictatorship to the democratic regime.

[423] Diana KAPISZEWSKI, 'Power Broker, Policy Maker, or Rights Protector' (2011) HELMKE, Gretchen; RIOS-FIGUEROA, Julio Courts in Latin America Sl: Cambrigde University 154; and Fernanda Mercier Querido FARINA, 'Técnicas de Agregação de Demandas Repetitivas: uma análise comparativa da experiência norte-americana em busca da eficiência processual', Universidade de São Paulo 2014)

[424] In 1990, facing a galloping hyperinflation, President Fernando Collor de Mello blocked the access to people's bank savings. The measure reduced 80% of the monetary circulation in the country, but it also resulted in financial damages for millions of Brazilians, who then resorted to the Judiciary seeking damages. The wave of repetitive litigation against Collor's plans flooded the Brazilian courts for more than three decades. In 2010, there were still 900,000 pending lawsuits in Brazilian courts (https://www.conjur.com.br/2010-mar-14/pais-900-mil-acoes-resgatar-50-bilhoes-plano-collor).

As said before, the Brazilian Constitution of 1988 was the most important symbol of the democratic transition – hence its nickname, 'the citizen Constitution'. It translated the promises of a system which would protect Brazilians against an authoritarian government and compensate for the 25 years of rights abuses. In this aim, the constitutional text of 1988 was filled with an extensive list of individual and socio-economic rights[425], which not only conferred liberties upon citizens and access to social rights but also overloaded the State with burgeoning duties. According to a public defender interviewed, the political choices written into the Constitution of 1988 meant that the State now needed to uphold the protection of its citizens (including by providing universal and equitable access to public health care).

> I know that [the judicialisation of health care] is a very difficult theme. I even empathise with the judge, with the weight of deciding those cases. But I think that the origin of this problem is that the [Brazilian] State made a choice. And, in my view this choice cannot be taken back: we have reached the constitutional civilising stage that requires [this type of protection]. (…) And then people say: 'but who pays the bill?'. We all pay the bill. That was the choice of our representatives in the constituent process of 88[426].

The public defender's quote illustrates the symbolic weight of the new Constitution as a *civilisatory* advancement. Consequently, citizens expect to receive from the government the rights (both individual and collective) promised in the Constitution. When those expectations are not met, then the Constitution also promises an enforcement mechanism, via litigation (justiciability).

The public defender's interpretation of the constitutional protection of social-economic rights are part of a collectivist notion according to which the costs of delivering such rights to

[425] In an interesting analysis of the political processes that underlined the democratisation of Latin America during the 90s, Roberto Gargarella attributes the length of the regions' constitutions not to the good will of the legislators, but to a form of coordinating the aspirations of different power groups. Talking about the said 'new constitutionalism' of the region as an expression of the "old" institutional structures already in place, Gargarella notes who the constitutions in Latin America were not designed to function as one cohesive text, but merely resulted from the agglomeration of different interests from the same elites that always dominated power in the region (GARGARELLA, *Latin American constitutionalism, 1810-2010: the engine room of the Constitution*).

[426] Interviewee 7 (2016) Interview with a public defender in Brasília (DF) [18/11/2016]

citizens should be supported by every Brazilian (i.e., when (s)he says that 'we all pay the bill'). Nonetheless, such interpretation refers not only to the idea that collective rights should be equally distributed and paid for by the whole of society, but also works as a response to the criticism made by many about the overbearing costs of health care litigation which only benefit the few individual litigants (and thus unequally shrinks the public budget which serves the many[427]). According to the public defender's view, the costs of litigation are also part of the political choice made by the Constitution of 1988, and as such must be borne by every Brazilian.

As analysed in Chapter 5, the 1988 Constitution introduced a legal framework which allowed for the increase of judicial power and the flood of rights-based lawsuits in all levels of Brazilian Judiciary. Moreover, in parallel to universalising of the right to health care[428] the Constitution also provided for a fundamental right of *access to justice*. According to the Constitution, 'the law may not exclude from review by the Judiciary any injury or threat to a right' (article 5, XXXV)[429]. Analogously to the extensive interpretation granted to the right to health care, the fundamental right to justice is also extensively interpreted by Brazilian courts as every citizen's right to a *day in court*. Hence, courts developed the interpretation that the Brazilian Constitution widened the gates of the Judiciary, where litigants can discuss any grievances. The combination of an ample provision of social-economic rights with wide doors to litigation created the *juridical* steppingstone for thousands of individual litigations to be filed against the State, culminating in a *litigation fever*. According to a prosecutor from the State of São Paulo:

[427] Octávio Luiz Motta FERRAZ, 'Health inequalities, rights and courts: The social impact of the judicialization of health' (2011) Litigating health rights: Can courts bring more justice to health 99

[428] Article 196, CF 88: "Health is the right of all and the duty of the National Government and shall be guaranteed by social and economic policies aimed at reducing the risk of illness and other maladies and by universal and equal access to all activities and services for its promotion, protection and recovery".

[429] Article 5, XXXV, Federal Constitution, 1988, Brazil

> [T]he Judiciary can never close its doors, and the Judiciary of São Paulo upholds that social commitment. I was present at a meeting with the governor, where we were discussing how to reduce litigation, and the president of the court was clear when he responded: 'governor, we do not close our doors to citizens'. So, the Judiciary is aware of its social role, and as an institution it will not give up exercising its jurisdiction. (…) [W]hen the client (sic) arrives at the administration's counter and (s)he does not leave with the medication, or information, or is unable to even understand what is happening, then people feel that their right are being infringed, so they seek the Judiciary. Thank God! At least we still have that. This is good news for the Judiciary, right?[430]

As the quote from the public prosecutor illustrates, based on the Constitutional provision of article 5, XXXV, the Judiciary in Brazil has assumed an institutional position which never denies access to the citizens. When the notion of *access to* justice, instead of being understood as a wider concept[431], is reduced to the exercise of a 'day in court', then the Judiciary becomes, as Garapon coined it, a *Mur de Lamentation*[432]. An institution which has the social responsibility to 'never close its door'. Under this interpretation of access to justice, and of the social role of judges in Brazil (analysed in Chapter 4), every matter becomes justiciable; the Judiciary must always interfere. This is the legal, constitutional framework which enables the *litigation fever* to take place in Brazil.

The litigation fever is a part of a wider phenomenon Charles Epp refers to as the "rights revolution"[433]. According to the author, the development of a structure that enabled civil rights to be expanded and enforced through courts, is a product of a bottom-up process originating from the deliberate, strategic action of rights activists – rather than the result of judicial

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[430] Interviewee 29 (2017) Interview with prosecutor in São Paulo (SP) [12/01/2017].

[431] As per Cappelletti's concept, access to justice must be understood as part of citizenship, as people's legal empowerment through knowledge, action and an access which is equitable and effective (Mauro CAPPELLETTI and Bryant G GARTH, *Access to justice: the worldwide movement to make rights effective: a general report* (AW Sijthoff 1978))

[432] Antoine GARAPON, *Le gardien des promesses: justice et démocratie* (Odile Jacob 1996)

[433] Charles R EPP, *The rights revolution: Lawyers, activists, and supreme courts in comparative perspective* (University of Chicago Press 1998).

activism. Similarly, according to Silva and Terrazas[434], in Brazil the explosion of health care litigation is not a by-product of courts acting as an 'institutional voice for the poor'[435] – as some judges I interviewed seemed to believe. Rather, litigation in Brazil does not improve the well-being of the most vulnerable population in the country.

The widening of the judiciary doors has invited the multiplication of repetitive litigation and incentivised repeated players[436] who use the courts as a means for achieving their personal and economic interests. As a result, instead of becoming a tool for redistributive justice, litigation widens inequalities and produces systemic inefficiencies. According to Gabbay et all:

> [R]epeat players enjoy great advantages in the Brazilian setting and are able to influence judicial and procedural reforms in order to maintain and strengthen its capabilities of manoeuvering a highly overloaded judicial system. The empowerment of one-shooters, one the other hand, relies on a redistributive approach to access to justice, prioritizing proceedings and structures that provide for an easier access and more adequate responses to individual claims involving such litigants.[437]

The case of health care litigation is not different. The widening of the judiciary doors through lower court fees and the incentive arising from high success rates has fuelled the interest of the economic power, such as pharmaceutical companies, which (ab)use of the judicial system by indirectly financing litigation and shortcutting the administrative controls. Furthermore, the high success rates of health care litigation also remove resources from the system, which would be used more equitably amongst all citizens, instead sequestering for the funding of drugs and treatments requested by those who litigate. As pointed out by one public

[434] DA SILVA and TERRAZAS, 'Claiming the right to health in Brazilian courts: The exclusion of the already excluded?'
[435] The authors draw from the analytical framework designed by Gloppen in Siri GLOPPEN, *Courts and social transformation: an analytical framework* (na 2006)
[436] Marc GALANTER, 'Why the haves come out ahead: Speculations on the limits of legal change' (1974) 9 LAw & Soc'y REv 95
[437] Daniela Monteiro GABBAY, Paulo ALVES DA SILVA, Maria Cecília DE ARAUJO ASPERTI *and others*, 'Why the'Haves' Come Out Ahead in Brazil? Revisiting Speculations Concerning Repeat Players and One-Shooters in the Brazilian Litigation Setting' (2016) Revisiting Speculations Concerning Repeat Players and One-Shooters in the Brazilian Litigation Setting (January 15, 2016) FGV Direito SP Research Paper Series

defender[438], those who litigate – even the ones who use the public defender's office – are not the poorest and most vulnerable.

Furthermore, in order to enable this conception of *access to justice*, the court system had to be strengthened and heavily funded. As a consequence, Brazil has today one of the most expensive judiciaries in the world[439]. This heavy and expensive structure has not resulted, however, in the desired redistributive justice in Brazil, as the poorest citizens are still unable to access the legal and judicial system[440]. It has, however, incentivised mass and repetitive litigation, which clog up the courts and delay the result of judicial proceedings.

As part of the legal machinery built to allow unrestricted access to courts, in 1995 the Brazilian Legislature introduced the small claims courts, which helped to commodify litigation - especially in relation to consumer law. The small claims court are today also an important avenue for litigation of health care,.

Starting legal action in a small claim court in Brazil is completely free of (monetary) costs in cases involving of up to R$40,000.00 (the equivalent of 40 minimum wages, and circa £6,000). When the claim is below R$20,000.00 (the equivalent of 20 minimum wages, and circa £3,000) then the parties are also exempt of legal representation. This means that starting legal action often costs *zero* and does not involve a lawyer at all. Additionally, in claims involving higher sums (i.e., not filed in the small claims courts), parties are still able to ask the court for fee remission (*justiça gratúita*) based on a low-income claim. The problem pointed out by interviewees, however, is that very often legal gratuity is granted without rigorous

[438] Interviewee 46 (2017) Interview with public defender in Florianópolis (SC) [02/02/2017]

[439] Brazil's Judiciary costs to the public coffers an annual sum that represents 1.35% of its GDP (in 2015), compared to the USA at 0.14% of GDP, Italy at 0.19% of GDP, Germany at 0.32% of GDP, India at 0.08%, for example. (Luciano DA ROS, 'O custo da Justiça no Brasil: uma análise comparativa exploratória' (2015) 2 Newsletter Observatório de elites políticas e sociais do Brasil NUSP/UFPR 1)

[440] GABBAY, ALVES DA SILVA, DE ARAUJO ASPERTI *and others*, 'Why the'Haves' Come Out Ahead in Brazil? Revisiting Speculations Concerning Repeat Players and One-Shooters in the Brazilian Litigation Setting', FARINA, 'Técnicas de Agregação de Demandas Repetitivas: uma análise comparativa da experiência norte-americana em busca da eficiência processual

parameters, resulting in abuses and incentivising the multiplication of lawsuits. According to a Superior Court justice:

> I think the cause of the Judiciary being so overwhelmed, so overloaded, is that it's too easy to access courts and it's too cheap to litigate. We don't have any kind of deterrence. (…) The access to justice is trivialised in Brazil. [Access to justice] shouldn't be understood as access to courts in any circumstances, at any time, without any costs. (…) When we suggest increasing the legal fees of appeals then the reply we hear is: 'oh no, but the access to justice'… It costs R$160 [circa £30] to appeal to the Superior Court of Justice. The judicialisation in Brazil is an industry, and not only in health care. It is very complex to dismantle it, you would need to face multiple interests[441].

The critique of the Superior Court judge reflects an overwhelmed judicial system, suffering from this *litigation fever*. The multiplication of individual claims overloads courts leaving judges with very little time to analyse each case. According to the yearly report produced by the National Council of Justice (CNJ)[442], in 2018 there were 28 million new cases filed in the Brazilian Judiciary – roughly one lawsuit for every 100 Brazilians. By the end of 2018, there were more than 78 million cases pending decision. The inevitable consequence of this multiplicity of lawsuits is perceived in the overload carried by the 18,141 Brazilian judges: long waiting times for decisions and, according to Supreme Court Justice, 'decisions being delivered without the quality they should have'[443]. Also, according to the National Council of Justice's report, in 2018 each judge in Brazil decided an average of 1900 cases. This means each judge analysing and deciding on average, 7,5 cases per day. Roughly one lawsuit per working hour.

> The judge has so much demand in Brazil; we are asked to decide all the time. We don't have time to do things as we would like to do, the system almost invites you to decide and 'see what happens' after the appeal. What I am not allowed to have is the lawsuit

[441] Interviewee 50 (2017) Interview with Superior Court of Justice judge in Brasília (DF) [07/02/2017]

[442] Interviewee 46 (2017) Interview with public defender in Florianópolis (SC) [02/02/2017]

[443] Interviewee 50 (2017) Interview with Superior Court of Justice judge in Brasília (DF) [07/02/2017]

> sitting on my desk. Furthermore, most lawsuits are repetitive. The system does not allow me to think about it for too long, because the caseload is huge[444].

As the quote from the São Paulo judges depicts, the *litigation fever* is a socio-legal phenomenon which overloads judges and jeopardises the quality of judicial analysis. However, as pointed out by the patients' association representative quoted above, the *litigation fever* is more than a legal issue. It is above all a cultural phenomenon, which commodifies litigation as a means of getting access to the public service and goods the litigants wish to consume. And whereby letting judges decide individual problems becomes a *convenience*.

Interestingly, this *convenience* is not only enjoyed by citizens and private companies, but also by the State itself. For instance, a report from the Brazilian Magistrates Association (AMB) from 2018 showed that the states – federal, regional and municipal – is the largest litigator (in number of claims), followed by banks[445]. Litigation is thus deeply entrenched not only in people's way of resolving problems but in the institutional culture of the country as well – a *jeitinho*. According to a private attorney, the judicialisation is a way for the administrator to 'get rid of his/her problems and [later] blame it on the judge'[446].

The culture of litigation must be therefore understood in light of the sociological context of post-colonialism (as analysed in Chapter 2). Albeit the Brazilian legal system and its institutions exert formal contours, exemplified in the lengthy Constitution, complex regulation and independent institutions, it also still shows strong remnants of such a colonial society. In particular, the vestige of a clientelist and authoritarian[447] society is reflected in the

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[444] Interviewee 24 (2016) Interview with appellate judge in São Paulo (SP) [14/12/2016]

[445] According the AMB's report, in 2013 the Public Administration started more than 70% of all lawsuits in the São Paulo Courts. In the same years, banks were defendants on 58,7% of all lawsuits (Associação dos Magistrados do BRASIL, *O uso da justiça e o litígio no Brasil*, 2018))

[446] Interviewee 33 (2017) Interview with private attorney specialised in health care law in Rio de Janeiro [25/02/2017]

[447] Mathias Spektor talks about how albeit democratic, the Brazilian society and power structure are still very much influenced by the authoritarianism of the military dictatorship. And, embedded in democratic contours and

distrust of people against public institutions (analysed in Chapter 4), and the lack of a collective sense of citizenship.

The still young republicanism in Brazil and the consequent individualist relationship of Brazilians with the public sphere fuel the utilitarian relationship with the Judiciary, which ends up, metaphorically speaking, being transformed into a pharmacy counter. When the right to health care is interpreted as an individual right, instead of a *social*, collective right, then each person's perceived entitlement to universal care clashes with the collective interest of an efficient public policy – which encompasses the tragic choices of dealing with a limited budget and a large population. Those who can reach the Judiciary are inevitably favoured against the rest of the population[448].

6.2. A culture of individualism and litigation: consuming health care via courts as a *jeitinho* around social inequalities in Brazil

> [T]he other day I met a girl and she said that her husband needed a bed at the ICU. She lived in Guapimirim; her husband was admitted to Nova Iguaçu. It's very far away. Even so, she visited him every day. [They got the ICU placement] through an injunction. Because if not, they wouldn't be able to get any hospital placement at all. Not in Brazil. I don't know how it is in other countries, but in Brazil it doesn't happen[449].

As I explore in Chapter 2, Brazilian institutions are affected by patrimonialism since the colonial period. With the urbanisation of the country, the power that was once held by rural landowners (*senhores de terra*) shifted to the political and economic elites of the cities. Even after the independence of the country in 1822 and the foundation of the Federal Republic in 1889, traces of the colonisation could still be felt, and are until this day. Now, however, the

discourse, the authoritarianism is still exercise in all levels of power in Brazil (Eduardo MELLO and Matias SPEKTOR, 'Brazil: The costs of multiparty presidentialism' (2018) 29 Journal of Democracy 113).

[448] FERRAZ, 'Harming the poor through social rights litigation: lessons from Brazil'

[449] Interviewee 20 (2016) Interview with litigant in Rio de Janeiro (RJ) [09/12/2016]

colonisers are the private interests of the powerful ones who take possession of the public machinery – otherwise known as patrimonialism or privatisation of the public sphere. However, the quote above, extracted from an interview with a litigant from Rio de Janeiro, illustrates how the colonial traits permeate not only the high ranks of politics in Brazil, but all segments of society, spreading through most social interactions. They can be identified in the every-day petty corruption, use of personal favours, bending of the rule for personal gain, etc. As the rules get a blurrier, the choice between individual gain and the collective interest are a no-brainer. Between being able to access, for free, an expensive drug, or cutting the queue of an organ transplant, in detriment to the others who will not be covered or who will wait longer times, most would choose the first. Even if they know such decision is wrong from a moral point of view.

> They say that everyone has the right to health, whether they have money or not. This may be burdensome for the Judiciary, if you think about the overload for judges. But that's their problem. I have to think about my problem, which is that I have get the medicine I need. So, each one with their own problem. The State must manage its resources to serve the population and the Judiciary must have the capacity, technical knowledge to assess the causes consistently and properly.[450]

This modern[451] form of patrimonialism has given rise to deep social injustices and wide inequality. Furthermore, in the modern, digitally connected world, the *perceptions* of injustice become much more tangible to people. With democracy and the rule of law, came also the expansion of awareness about the individual and social rights entrenched in the Constitution.

[450] Interviewee 23 (2016) Interview with litigant in Campinas (SP) [12/12/2016]

[451] Modern in the sense that it is distinguished from the original concept of patrimonialism developed by Weber, based in a traditional domination of the power elites.

The constitutionalisation of rights shed light onto the inequalities and the privileges of the elites, increasing the generalised feeling of unfairness[452], to which judicialisation became an alternative compensation.

> Unfortunately, the judicialisation is a necessary evil. (…) The lawsuits force the State to give the drug and to find the resources to do so. They find a way to raise the resources because otherwise there is a sanction. (…) Health is everyone's right, the Constitution says it is a universal right (…). Is it unfair to those who are also in the queue for someone who has no urgency to pass in front via litigation? It is. But when a person goes to the Judiciary to seek their right and the courts are triggered, then the judge has to decide. (…) And it is in the Constitution that if you are a citizen, who pays your taxes, then you have a universal right to health. So, if you have a medical prescription for surgery or you have a health problem, then you will be operated. (…) In theory, in paper, the SUS is very good, but in practice, due to lack of resources, it is unable to serve everyone. So, those who litigate end up being treated faster than those who do not litigate[453].

According to the prosecutor's reflection, litigation against the State is a necessary evil, even if it knowingly accentuates the inequalities of the system, by privileging those who can litigate.

The full exercise of citizenship[454] requires from the right bearer awareness of his/her individual rights and empowerment to enforce them. Citizenship also encompasses civic duties and the conscience of being a part of the collective. As part of society, the fruition of individual rights is sometimes restrained in favour of the collective interest. Nevertheless, the structural inequalities present in Brazil make it impossible for the marginalised to fully exercise their citizenship and civic duties. In the letters of the formal law, Brazilians are all equal and equally entitled to a robust net of social rights. That, however, is, according to Roberto Schwartz, 'a

[452] Bernardo SORJ, *A nova sociedade brasileira* (Zahar 2000)

[453] Interviewee 34 (2017) Interview with public prosecutor from Campinas (SP) [16/01/2017]

[454] Turner defines citizenship as 'the set of practices (juridical, political, economic and cultural) which define a person as a competent member of society, and which as a consequence shape the flow of resources to persons and social groups. Turner also alerts for the complexity of citizenship and how it cannot be restrained to the juridical concept, which would limit it to the rights and duties imposed by law. Furthermore, the author addresses the importance of observing the exercise of such rights and obligations, and the social forces and arrangements that produce and influence such practices (Bryan S TURNER, 'Contemporary problems in the theory of citizenship' (1993) 24 Citizenship and social theory 1)

misplaced idea'[455]. Liberal institutions in Brazil reflect the discrepancies of social practices with the formal law. Whilst on the one hand the formal law promises Brazilians a Welfare State similar to Switzerland, on the other hand the State is unable to fulfil the constitutional promises. The true reality of Brazil, of the *jeitinho*, and its patrimonial, unequal reality, showcases the infinite discrepancy between the quality of services enjoyed by the elites and those of the rest of society.

How, then, to feel part of society and exercise all aspects of citizenship when the State and the powerful marginalise a big part of society? How to develop a sense of collectivism and exercise the civic duties social life requires, when the fruition of social-rights and the liberal institutions are a 'misplaced idea'? The paradoxical reality of Brazil, where instead of emanating from the hands of the people, power concentrates in the hands of few, distorts the basis of its democracy. The democratic legitimation, albeit formally present, is not felt in the social practice. And, in turn, people protect themselves and their close ones against the powerful few. In such a context, litigation is understood as an individual way around inequalities – even if not really producing progressive outcomes.

Central to the deep inequalities in Brazil is the access to different quality of basic services, like health care and education, which in turns stagnates social development and the reduction of inequality itself. An uneducated society is unable to develop intellectually and economically, and to then fully understand and exercise their citizenship – both in terms of knowing their rights and of exercising their civic duties. As Sorj points out[456], Brazilian sociability lacks civic components. The individual and the collective political identities become distanced from one-another.

[455] Roberto SCHWARZ, 'Misplaced Ideas: Literature and Society in Late Nineteenth-Century Brazil' (1980) 5 Comparative Civilizations Review 3

[456] SORJ, *A nova sociedade brasileira*

The result of a patrimonial State and deep-sited inequality not only erodes trust between citizens and the public institutions, such as explored in Chapter 4, but also fosters a *clientelist* and commodified relationship between citizens and the public sphere. In such a relationship citizens expect to be able to individually consume public goods and services (such as health care) when paying for it (via taxes).

Therefore, the commodification of the public sector is intimately related to the citizens' individualism. Although Brazil is considered by part of the literature[457] to be a collectivist country, the gregarious nature of Brazilians relationship value and protects the immediate networks, such as the extended family. This form of 'collectivism' cannot be mistaken for the collective notion of citizenship which I talk about in this section. On the opposite. The relevance of these groups only highlights a mechanism through which Brazilians protect themselves and their close ones against a perceived corrupt and inefficient State. The same phenomenon is observable in countries like Italy, which have similar issues of trust and perceptions of corruption, and which place great importance in the associative groups, like family and the mafia[458].

6.2.1 The commodification of the public sector in Brazil

[457] For example, according to the analysis of Hofstede Insight, Brazil is a collectivist country. The analysis is based in quantitate study through questionnaires and have scored Brazil 38/100 points in Individualism dimension. According to the research, Brazilians 'are integrated into strong, cohesive groups (especially represented by the extended family; including uncles, aunts, grandparents and cousins) which continues protecting its members in exchange for loyalty. (https://www.hofstede-insights.com/country-comparison/brazil/, accessed on March 26th, 2020). And, Virginia MS PEARSON and Walter G STEPHAN, 'Preferences for styles of negotiation: A comparison of Brazil and the US' (1998) 22 International Journal of Intercultural Relations 67

[458] Paul GINSBORG, 'Family, culture and politics in contemporary Italy', *Culture and Conflict in Postwar Italy* (Springer 1990)

The Brazilian administration has undergone several bureaucratic reforms with the intention of modernising the public machinery in the last decade[459]. However, such reforms are criticised for mostly aiming at the finance capital and the attraction of foreign investments[460]. Particularly due to a long period of hyperinflation during the 80s and 90s, the government efforts focused on controlling the monetary policy – with economic plans such as the ones imposed by Collor that led thousands to courts, mentioned above - and rescuing a few economic sectors, such as the agribusiness. Critics point out to how these reforms and governmental efforts were rarely focused on the poor, on reducing inequalities and improving the quality of basic public services, such as education and health care[461].

Furthermore, the incapability of the State to control the inflation expanded the distrust of the public machinery. Whilst a few Brazilians – and foreign investors – profited from the State through public contracts and high interest rates, for the masses, the State merely meant taxes and violence. It was clear that Brazilians were not equal. So, how could the State at least create the illusion of equality?

A way the Brazilian government found for dealing with the economic problems was to incentivise consumerism and to adopt a consumption-centric discourse, which would later be used as a narrative to justify the privatisation wave of the 90s. As sociologists point out[462], the Brazilian society is deeply marked by this consumerism, typical of the North American social model. Boosting consumerism through a narrative centred in individualism, was a way to make people feel a part of society. By owning a fridge, a telephone or being able to access the internet, Brazilians would be granted a sense of basic well-being and sociability.

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[459] Luiz Carlos Bresser PEREIRA, *Reforma do Estado para a cidadania: a reforma gerencial brasileira na perspectiva internacional* (Editora 34 1998) and PINHO and SACRAMENTO, 'Brazil: between the modern bureaucracy of Weber and resilient patrimonialism'

[460] SORJ, *A nova sociedade brasileira*

[461] Wilnês HENRIQUE, 'O capitalismo selvagem: um estudo sobre desigualdade no Brasil' (1999)

[462] Hugo Chaves B FERREIRA and João Policarpo R LIMA, 'A insustentável leveza do ter: crédito e consumismo no Brasil' (2014) Revista da Sociedade Brasileira de Economia Política

For a time, and in some respects, the strategy worked. During the mid 2000, the Brazilian economy grew, inequality was reduced and the middle-class gained newcomers. With credit soaring, Brazilians indebted themselves by financing expensive goods such as iPhones and Nike shoes. Consumerism also becomes a manner of dealing with the lack of good quality public services. As an example, Brazil's high number of private cars (the highest per person in South America[463]) could account for a private, consumerist solution for the low quality of public transportation across the country. Owning a car becomes a necessity where public transportation is scarce and of bad quality. It is also a *status*, a sign of wealth and a way to belong to a privileged group. Measuring the quality of someone's life is thus directly related to the price of the product they can acquire. Citizenship is replaced by purchase power.

Alongside the development of this consumerist narrative, the Brazilian legislator also created a strong legal framework to protect consumer's rights. This included strong collective legal action and an easier, cheaper, and faster way to access the Judiciary. As a result, consumer law commodified the access to the small claims court as well. This network strengthened the feeling of acquired citizenship through consumerism, which now could be enforced and recognised by courts as a right. And through the protection of consumer rights, civil society and the Judiciary found a way of safeguarding citizens against patrimonialism and the colonisation of the State by private interests. Finally, companies would pay for the damages caused to the people. Banks then became the largest defendant in Brazilian courts and the consumer rights legislation empowered the civil society, the Prosecutor's Office and the individual litigant, who could now have a *free* day in court. Was there finally Justice for Brazilians against the colonising capital? Not really. But now at least there was a fractional *access to justice* – another *jeitinho*.

[463] https://www.nationmaster.com/country-info/stats/Transport/Passenger-cars/Per-1,000-people#2007, accessed on 25/03/2020

In a commercial relationship, the consumer gets what they pay for. In a consumerist society, the same logic is transported to the public sphere. By paying their taxes, citizens expect to get from the State what they paid for: individual fruition of public services, when they need it, for what they need it. Irrespective of the public policy. The 'right to everything'[464].

M., the mother of a 4 years-old ALS patient, is an example of this dynamic between marginalised citizens and the Brazilian State. Inside the one-bedroom house at a *favela* of Brasília, where a homecare ICU bed takes most of the living room space, M. reflects about her right to access the medication and homecare for her daughter, enforced via litigation:

> [The judge] had to give me the medication, my daughter is not to blame for her illness. And the government has money to pay for it. I pay R$50 for water, I pay R$50 reais for sewage. What is that for? (…) Where does that money go? It goes to their pockets, so that they can eat well, eat filet mignon! So, they have to give the medication, we have to get it. They should defend the population and that is why we pay taxes, very expensive taxes. There has to be a benefit, right?[465]

The external, structural factors of deep inequalities, individualism and commodification analysed so-far come all together, entangled in M.'s words: a deep-rooted distrust in the perceived corrupt government and the belief in the righteousness of her request for medication and homecare, fuelled by the sense of being abandoned by the State which does not assist her family, despite paying expensive taxes. M. is an example of the Brazilians who feel excluded from the State and are thus unable to fully exercise their civic duties. For them, engaging in legal action against the State generates a feeling of formal interaction with the State. One which would be otherwise impossible. 'Litigation forms a mode of practice that, dialectically, possesses both inner- and counter-systemic status'[466].

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[464] FERRAZ, *Health as a Human Right: The Politics and Judicialisation of Health in Brazil*

[465] Interview with winning litigant from Brasília on November 17th, 2016.

[466] In Chris THORNHILL and Maria SMIRNOVA, 'Litigation and political transformation: the case of Russia' (2018) 47 Theory and society 559. In this paper, Thornhill and Smirnova reflect on how the 'Russian case provides a sociological perspective in which we can understand the importance of legal actions in hybrid polities. It explains

The individual logic of consumerism which commodifies the public relationships, substitutes the collectivism necessary for a well lubricated society to function. In such a context, Brazilians transform their citizenship into a commodified, utilitarian relationship with the public sphere. Public services are treated as ordinary goods and the individualist logic of a consumerism is transported to the realm of public services, like health care. In this context, the next section focuses on the factors taken into consideration by individual litigants when deciding to start legal action against the State.

6.3 What factors influence the individual decision to start health care litigation?

In *Paths to Justice: what People Do and Think about Going to Law*, Professor Hazel Genn concludes that people in England and Wales are normally reluctant to go to court to enforce or defend their rights[467]. The survey conducted by Professor Glenn with over 4,000 participants revealed that the main reasons for such rejection of judicial process was based on fears of costs, a lack of confidence in the outcome of lawsuits, and a belief that judges serve the interests of the wealthier. The findings of this research through the in-depth interviews indicate different impressions arising from the interviewed litigant's experience.

That is not to say that litigating in Brazil is *easy* or that there are not barriers to the access to courts[468], however the utilitarian considerations referred to by the litigants

that litigation in Russia, even where it may have counter-systemic outcomes, is partly incentivized by the government, as promotion of access to law is seen as a means to formalize interactions between citizens and government and so to extend the societal penetration of the political system more generally'

[467] Hazel GENN and Sarah BEINART, *Paths to justice: what people do and think about going to law* (Hart Publishing 1999)

[468] For instance, according to Sadek, the socio-economic indexes of illiteracy, striking regional, economic and political inequalities, reflect a judicial system which is closed off to the great majority of Brazilians – especially the poorest and most vulnerable. The author highlights the apparent contradiction between the overall number of legal claims filed in the Brazilian judiciary (1 for every 2 Brazilians), with a higher growth rate of legal claims than population, versus the number of repetitive litigants who make use of the system, to illustrate the use of the court system by the economic elite (Maria Tereza Aina SADEK, 'Acesso à justiça: um direito e seus obstáculos' (2014) Revista Usp 55).

interviewed shed light on how simple the decision of starting legal action was vis a vis the cost of drugs/treatments/medical devices.

This does not mean that the various legal instruments designed to offer free access to courts enable an equalitarian, fair, and widespread access to justice in all corners of the country[469]. Even though the Brazilian legal system has developed strong legal aid instruments since the democratisation, there is still a very big part of the population, which is not educated about their rights, able to access legal representation or even aware of the existence of avenues such as the public defender's office. According to a public defender from Santa Catarina, differently to what the common knowledge would conceive, the Public Defenders' does not represent the claims of the most venerable Brazilians:

> [People usually learn about the Defender's Office] because the doctors tell them, or someone who has already come here and was successful. Word of mouth works a lot. We also go to the communities a lot to explain, educate people about their rights. We talk to community leaders, and they share the legal knowledge, so that is how these people end up learning about their right to litigate. In very few cases people are suspicious or scared of starting legal action. But the defender's office is not usually sought by the miserable portion of population. There are few cases of people in a situation of misery coming here. Most people that come to us are middle class people, or a lot of people who try to look poor to get free access to legal representation. Nobody wants to pay for a lawyer today, everyone wants to go to court for free.[470]

As pointed out by the public defender, the fact of the public defender's office is responsible for a large number of claims in the Judiciary, or that the court fees remission is granted to an average of 30% of all lawsuits filed before Brazilian courts, cannot be taken as an indicator that these numbers represent the interests of the most vulnerable Brazilians. There

[469] Through an economic analysis of free access to courts and legal aid, Arake and Gico argue that the legal gratuity incentivises risky litigation rather than widening the access to justice. Their argument strengthens the claim that the structures of litigation in Brazil do not result in redistributive justice and progressive outcomes, but rather widens inequality by offering a smaller part of the population the use of courts for personal and economic interest (Henrique ARAKE and Ivo T GICO JR, 'De Graça, até Injeção na Testa: análise juseconômica da gratuidade de Justiça/If It's Free Then It's For Me: the law & economics of waiver of fees' (2014) 5 Economic Analysis of Law Review 166)

[470] Interviewee 46 (2017) Interview with public defender in Florianópolis (SC) [02/02/2017]

is still a very large segment of citizens whose social-economic status prevents them to exercise the access to justice promised by the Constitution[471], which is also very unequally distributed throughout the country, as richer states can offer better legal aid than poorer ones.

Nevertheless, as explained in section 6.1 above, the Brazilian legal system has enabled a number of instruments to make the access to courts cheaper and easier, such as a far-reaching legal aid system (*justiça gratúita*) and strong public defender's offices.

> [The procedure] was so easy. It was very easy because I had a lawyer who did it for me for free. So that was very good for me, right?[472]

Although as mentioned above the major deterrent for starting legal action is usually related to the costs of representation and court fees[473], neither of these have been cited by the interviewed litigants as factors that could drive them away from the courts. With the chances of success reaching over 80% in relation to health care claims[474], litigants have only to weigh out the costs (including opportunity cost) of accessing legal representation *vis a vis* the costs of the drug/treatment need.

From all the eleven litigants interviewed, five did not pay any fees to start litigation - three were represented by pro-bono lawyers, one by the public defender's office and one had her/his expenses covered by an NGO. The other six were represented by private lawyers who they paid for.

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[471] Which is in line with the studies conducted by Octavio Motta Ferraz, for example, who support the thesis that health care litigation is detrimental to the most vulnerable Brazilians precisely because this segment of the population is not legally empowered (FERRAZ, 'Harming the poor through social rights litigation: lessons from Brazil')

[472] Interviewee 23 (2016) Interview with litigant in Campinas (SP) [12/12/2016]

[473] Susan S SILBEY, 'After legal consciousness' (2005) 1 Annu Rev Law Soc Sci 323

[474] DE AZEVEDO, ABUJAMRA and ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução*

V., a litigant from São Paulo who sued the State to access the hypoallergenic milk Neocate paid R$2,000 (circa £300) for her lawyer's service. Talking about what she considered before starting litigation, V. answered:

> I thought about the money, right? Because I wouldn't have enough to pay for the milk every month. My baby needed 16 cans of milk per month (…) which costs around R$3,500 (circa £500). That, plus the frustration, because we pay taxes, right? I pay my taxes correctly, and if I don't pay, the State comes after me. So, it's fair that when I don't get the milk I go after the State [via litigation]. When I go to the high-cost pharmacy to pick up the milk, I see the amount of people in need. So, I think it is not fair, that we pay our taxes and when we need something we cannot have it. Plus, my lawyer was very honest with me, she said: you know that now the people are no longer afraid of the Judiciary. No longer afraid of a judge, no longer afraid of anything. She said the judge was going to grant the access to the milk because everyone has the right to be healthy, you know? She said she was sure that the judge would grant it, because I had the doctor's letter [sic: referring to a medical prescription]. She also said that the judge believes in health care for everyone, no matter what.[475]

V.'s description of her decision to start legal action against the Secretary of Health of Campinas translates to a utilitarian and commodified relationship with the health care system and the Judiciary – as explained in sections 6.2 and 6.3 above. The decision was the result of a simple calculation which considered the (low) costs of litigating, and high chances of winning, *vis a vis* the high cost of the milk. Another litigant, J., who also sued the State to get access to Neocate milk frames her decision to start legal action in the same utilitarian manner as V.:

> If the judge had denied all [other] cases, I would not go to [the Judiciary]. (…) I don't know, honestly, I don't know what I would do, I think we would have to sell everything, sell the car to pay for the milk. This is what the government wants, right? They [politicians] think that if you had a child, it's your problem. (…) I don't know what the [Judiciary] wants, because each judge is one. My judge thought I was entitled to getting the milk, but there are certainly other judges who are in the hands of the mayor.[476]

[475] Interviewee 12 (2016) Interview with litigant in São Paulo (SP) [24/11/2016]

[476] Interviewee 19 (2016) Interview with litigant in Nova Iguaçu (RJ) [08/12/2016]

In the quote above, J. reacts to the hypothetical world where judges would deny access to drugs and treatments not included in the health care policy. She first raises the worry of not being able to afford it and having to find other ways to access the milk – i.e., selling her possessions. Soon, however, the idea of being denied access to a treatment for her son, is linked to a perceived corrupt government. One which forsakes children and mother's needs, and potentially corrupts judges to deny access too.

Although the utilitarian trust in the outcome of the legal action is an important factor for explaining the rise of successful health care claims, both quotes from V. and J., above, also associate their perceived right to access a medical treatment via litigation with the sense of being unfairly treated by their government (as explained in section 6.3. above). The question that I develop from that, then, is how does trust in the Judiciary and a sense of agency as a citizen are involved into the decision to start litigation?

6.4 Is litigating access to health care about trust in the Judiciary?

> When you tell [Brazilian] people to 'search for their right', they immediately think about litigation. They do not understand that the rights come before [litigation]. (…) [The Judiciary] is promoting a litigation mania. The person that goes to the Judiciary, (s)he has hopes and that comes true [when (s)he is granted her claim]. So, (s)he confuses this feeling with trust. (S)he thinks, I went [to the Judiciary] and got [what I needed]. What happens then? (S)he will go again. (S)he will not want to mediate, to try [other alternative dispute resolutions]. No, no, (s)he is going to sue. So, in this way, the Judiciary is promoting [litigation][477].

In Chapter 4 I explored how the distrust in the Executive is a central factor influencing judges' decision to grant health care lawsuits against the State. In the case of judges, their distrust in the health care public policy and the Executive's ability to fulfil the constitutional promise of universal access to health care fuels their willingness to grant the request of individuals for treatments and drugs not provided by the public system. In that Chapter I

[477] Interview with federal public defender in Brasília on November 11th, 2016.

explored how the judges' distrust is grounded in a culturally constructed belief that politicians in Brazil are corrupt or inept. In this Chapter I explore what – if any - role trust in the Judiciary plays in the litigants' decision to start legal action. And, if so, what is the nature of that trust.

Trust is considered to be an essential social capital[478] and for some it works as a true thermometer for democracies and the legitimation of their institutions[479]. This means that people's trust in their governments and leaders can strengthen democracies and improve the legitimation of governments. However, the different trust indexes which measure trust in public institutions, point out to a generalised decline in citizen's trust in governments of the western world[480]. In Brazil, the trend is not different. In fact, Brazilians have the lowest trust level in political parties amongst all American countries[481]. According to the 2018 national trust index produced by Datafolha[482], 67% of Brazilians responded that they 'did not to trust' the Congress, 68% 'did not trust' political parties, and 64% 'did not trust' the President. The Judiciary, however, showed better indexes in that research: only 31% replied they did not trust the courts, while 48% said they trusted it somewhat and 19% responded they trusted a lot.

These numbers can spark the question if the Judiciary in Brazil in a way compensate for the citizens lack of trust in their representatives. If Brazilians trust the Judiciary – even if up to a certain level - what does that trust entail? Could trust be one of the factors behind the increase of health care litigation in the country?

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[478] PUTNAM, LEONARDI and NANETTI, *Making democracy work: Civic traditions in modern Italy*

[479] MATTHEW R CLEARY and SUSAN C STOKES, 'Trust and democracy in comparative perspective' (2009) Whom can we trust 308

[480] Felix ROTH, Felicitas NOWAK-LEHMANN D and Thomas OTTER, 'Crisis and trust in national and European Union institutions: panel evidence for the EU, 1999 to 2012' (2013) ; and MORI IPSOS, *Ipsos MORI Veracity Index 2016: Trust in Professions* (Ipsos MORI, London 2016)

[481] Informe LATINOBARÓMETRO, 'Corporación Latinobarómetro' (2016-2017) Santiago de Chile , 2018

[482] DATAFOLHA, *Grau de Confiança nas Instituições*, 2018) available at http://media.folha.uol.com.br/datafolha/2019/07/10/9b9d682bfe0f1c6f228717d59ce49fdfci.pdf

What the data collected from these litigants' interviews shows and what was further confirmed by the accounts of private attorneys and public defenders, is that trust is indeed a key factor influencing litigant's decision to start legal action. However, different from the nature of the trust identified in judge's interviews – i.e., a cultural constructed notion of inefficiency and corruption, the trust expressed by litigants was *utilitarian*, and related to the outcome of the legal procedure rather than to the ethics of the judges, or the Judiciary more generally.

For example, L[483] was a litigant interviewed in São Caetano, a city of the state of São Paulo. (S)he is diabetic and was prescribed a special, automatic insulin pump by her/his doctor. One which is not included in SUS's medication list, but that is more efficient in controlling the patient's glucose. This means that L. would have to buy this pump and the monthly supply from her/his own expenses or continue to make use of the insulin provided by SUS, which has to be administered manually. The automatic pump prescribed by L.'s doctor costs around R$20,000 (circa £3,000) in the Brazilian market, and the supply would cost her/him, monthly, around R$4,000 (circa £600) more. (S)he could not afford to buy it herself/himself. So, her/his doctor suggested that (s)he tried to get the pump and the insulin through the Judiciary, by suing the State:

> The doctor gave me all the advice [to start legal action], the entire step by step. (S)he suggested some lawyers who (…) are specialised in health care litigation. I went to the lawyer and (s)he asked me for all of my medical history (…) and then told me that there was a very high chance that I would get it, but if I didn't, we could try another lawsuit with different requests. (…) I paid R$3,000 for the whole legal procedure [circa £500]. (…) I don't know if I paid legal fees.

I then asked why (s)he decided to start legal action and if trust in the Judiciary was a component of her/his decision. (S)he replied:

[483] Interviewee 12 (2016) Interview with litigant in São Caetano (SP) [24/11/2016]

> [My decision to start legal action] took into account my health, improving the quality of my life. (…) I trust the Judiciary because I was sure I would get [the drug] there. I could not get it anywhere else. Only via Judiciary. (…) So, if I had to, I would [start legal action] again. I would go to the judge to get my medication, again. (…) From the State we are not able to get anything, because of corruption, bad use of the public money.

L's reply to my question was very similar to the other litigants' answers. We can break down the factors influencing his/her decision to start legal action in four different grounds: (i) the first, internal factor, relates to the more immediate reason for the legal claim: the necessity to access the drug; (ii) the second internal factor, which is closely related to the necessity factor, related to her/his inability to pay for the drug; (iii) the third, external factor, referred to the affordability of the legal fees in comparison to the cost of the drug. The cost of the pump alone was more than six-fold what the lawyer charged for his/her entire legal procedure; and (iv) finally, the fourth, internal factor, referred to her/his trust in the Judiciary, which in turn was based on her/his expectation of winning the lawsuit and thus accessing the drug (s)he needed.

At the end of her response, L. also refers to accessing the Judiciary as a *hope* for Brazilian citizens, who cannot rely on a government to provide health care. Thus, in a way, L. also talks about the Judiciary being the only option to fulfil her/his constitutional rights against a corrupt government.

One preliminary conclusion that can be taken from L.'s decision making process for starting litigation is that it was the result of a rational calculation: the cost of legal procedure *vis a vis* the price of the medication (s)he needed. Thus, access to information, legal representation and legal costs (including court fees) were essential components of the decision to start legal action. Another important part of this calculation was estimating the chances of getting her/his request granted by the judge. In other words, her/his utilitarian trust in the outcome of litigation. For that reason, the personal experience of one litigant or of someone

closely related to him/her informs this person's trust in the Judiciary and influences their decision to start new legal action. Moreover, when the one litigant's positive personal experience is transmitted through the 'word of mouth', then the personal expectation of accessing health care through the Judiciary are transferred to others.

As the personal trust is experience and transmitted, it becomes part of a 'social trust'[484] - a generalised expectation that the same result will be reached every time. As Kaase points out, the development of trust depends 'on interactions over time and with satisfactory outcomes'[485]. Therefore, the succession of successful outcome overtime sediments people's expectation, enhancing their utilitarian trust[486] and incentivising others to start legal action.

Moreover, litigants who had previous positive experiences with legal action expressed a strong degree of trust in the Judiciary, even when those other experiences were not directly related to health care litigation. V., for example, a litigant who sued the state of São Paulo to get access to a hypoallergenic milk not offered by SUS, says that before that lawsuit, she had been successful in a guardianship dispute with her ex-husband, which had also been resolved quickly. That earlier, positive experience, fuelled her confidence that she would also be victorious in her lawsuit against the city of Campinas.

> I would say I trust the Judiciary. Because all the cases I have tried before have worked (…). So, I trust it... For example, [my divorce] took less than a month, and in that little time I secured my son's custody, and pension. If the judge gave me the guardianship, if I always got everything I asked for [in the Judiciary], then I end up trusting it[487].

[484] 'Social trust deviates fundamentally from individual trust, because the trust is expanded to include people about whom the trusting party has no direct information. Thus, social trust reflects a positive perception of the generalized other' [Gert Tinggaard Svendsen, *Trust* (Reflections 1, Narayana Press 2014)]

[485] KAASE, 'Interpersonal trust, political trust and non-institutionalised political participation in Western Europe'

[486] James Wood BAILEY, *Utilitarianism, institutions, and justice* (Oxford University Press on Demand 1997)

[487] Interviewee 12 (2016) Interview with litigant in São Paulo (SP) [24/11/2016]

Such confidence in the outcome of litigation is then shared by other actors, such as a medical doctor interviewed in São Paulo:

> Of course [litigants] trust the judges, because they win. Anything you judicialise [in Brazil], you win (…). I am not aware of one single case that lost, at all. I do not know of any patient who went to court asking for a surgical procedure, a prosthesis, an orthosis, who has not won[488]

The utilitarian nature of litigant's trust in the Judiciary is further confirmed by other legal representatives, both private attorneys and public defenders. A public defender from Rio de Janeiro, for example, explains how by granting the lawsuits the Judiciary is feeding people's trust in courts. According to the defender, the use of litigation is so deeply entrenched in the Brazilian's minds that even professionals from the public health care system, SUS, recommend that patients seek the public defender's office and start legal action:

> I think it is a vicious circle, the more you grant the more the population seeks the Judiciary. (…) Sometimes the patient would go to the public surgery and hears from the professional there: 'do not waste your time here, it won't work. Look for a public defender'[489].

Likewise, a judge from São Paulo acknowledges the utilitarian trust generated by the high-rates of successful health care claims:

> The Judiciary created a trust, with the various injunctions granted, so there is a trust that if you ask the Judiciary, you will get a certain medication. [A trust] that is very utilitarian and very individualistic. The supply of that medicine will not guarantee better health for everyone, so the issue is always individual care and not collective solution for a public policy that would benefit the overall health [of the population]. These [individual decisions] have no criteria, no parameters (...). I really do not see a way to reverse this situation, because the judicialisation is very consolidated [in Brazil][490].

[488] Interview with a medical doctor from the public and private systems in São Paulo on January 21st, 2017.

[489] Interviewee 37 (2017) Interview with medical doctor from SUS in São Paulo (SP) [22/01/2017].

[490] Interviewee 38 (2017) Interview with first-degree federal judge from São Paulo (SP) [22/01/2017]

Interestingly, the same utilitarian trust is not observed amongst litigants who lost.

6.4.1. A different nature of (dis)trust: an account from the few litigants who lost

Another interesting finding came from the analysis of litigants who lost their lawsuits. In the same way as winning litigants, litigants who lost also initially expressed a utilitarian trust in the expected outcome of their cases. However, when losing their claims, litigants expressed distrust in the ethics of the Judiciary, accompanied by a sentiment of wrongfulness and illegality. In the few losing cases, the generalised perception of corruption normally associated with politicians and the Executive were also extended to the Judiciary.

For example, S.[491], a litigant who sued the state of Minas Gerais to get access to the anticoagulant medication Clexane, talks about her case and how she does not trust the Judiciary because the judge did not grant her request. At the time of the interview, S. was unemployed and pregnant, and told me that if she did not make regular use of Clexane she could lose the baby and die. That, according to her, should have been reason enough for the judge to grant her claim. When asked why she decided to start the lawsuit, S. replied:

> I didn't decide if I was going to start [legal action] or not, because I had no other option, I had to litigate. The medication costs more than R$4,000 per month (circa £800) and I can't afford it.

Then, when asked if she trusted the Judiciary, S. replied:

> I don't trust anything. The State nor the Judiciary. Because how could a judge not grant the medication to a person who needs it? As I said, I was pregnant, with thrombosis, several other problems, I had no money, I was unemployed. Why would some people

[491] Interviewee 42 (2017) Interview with litigant in Belo Horizonte (MG) [28/01/2017]

> get it and not me? (…) I think there is a lot of illegalities involved, in everything. [Politicians] give excuses for everything, for not providing the medication people need.

As a consequence of her negative experience with litigation, S. expresses a general discontent of the judicial proceeding, from talking to lawyers to waiting for the lengthy bureaucracy. She then suggests that she does not trust the ethics of the Judiciary, because if other similar cases were granted and hers was not, then that must be an indication of 'illegalities'- referring to corruption. In the same way, G., a litigant from São Paulo suffering from multiple sclerosis who sued the State to have access to a *cannabis*-based medication, and lost twice, reflects:

> [T]he reason why I decided to sue is so that I have a proof that I'm trying. I don't have any trust in these guys [judges], especially now, in this political moment. I do not trust the Judiciary. Because ... Let's start with the example I have at home: my mother is a seamstress; she works at a clothing repair company. But landlords always raised her rent astronomically at the end of every year. Then once she decided to take the matters to court. What happened: the guys bought (sic) a lawyer and the judge to decide in their favour, and so she lost the case. Because there was corruption. We know that these people are only concerned with money. All of them. The politicians, the judges. Everyone who has an opportunity, robs. So, I don't know why I keep trying to litigate. I think because I have hope. I trust the doctors a lot, and they are on my side. I trust them with my eyes closed, and what they say, I do. So, I'm going to try again. Because it's for a bigger cause. After all, someone needs to change things. We need to insist. Then sometime someone will get one [positive decision] and then another, and in that way, we change the law. It is easier this way, through the Judiciary, than [by leaving] in the hands of these politicians[492].

What we can conclude from the accounts of S. and G. is that their negative personal experiences fuel their distrust in the Judiciary, and their belief that the judges too can be corrupt. This is confirmed by a public defender from Florianópolis. According to him/her:

> Usually when the person loses the injunction, (s)he thinks that the judge has been bought. In some cases, the person had not even tried to go to the public pharmacy to request the medication. In the cases of special medications, for example, the patient

[492] Interviewee 53 (2017) Interview with litigant from São Paulo (SP) [24/02/2017]

> must start an internal administrative procedure to get access to it. They cannot just go to the pharmacy with the prescription and get it. It is a bureaucratic procedure. So sometimes the person thinks: 'I will go to the public defender's office, because it will be faster [to sue the State]'. [493]

The *convenience* of litigating, expressed in the public defender's statement, shows an important feature of the utilitarian and individualistic relationship developed with the public sphere. In this scheme, Brazilians will search for the easier, fastest way to access what they need, because they believe they have "the right to it". Given the widespread perception that the Executive and the public administration is either corrupt or inept to fulfil their constitutional obligations, Brazilians search for the safest, most (perceived) effective course: the Judiciary. If, however, their expectations are not confirmed by a success outcome of their lawsuit's outcome, then they immediately reject the validity of the legal process, through a perception of corruption.

> It is not that they trust [the Judiciary]. I think that in Brazil, unfortunately, it is impossible to know in which institution to trust. In Brazil, the public consciousness is to search for the public authority who will solve my problem. It does not matter how [they will solve it]. Even if the litigant knows that the lawyer who is conducting the case is a criminal, that the pharmaceutical companies are close to the Judiciary - for the person who need the drug, the only thing that matters is the outcome. Is the fact that before [starting litigation] they did not have the medication, and now, after going to the Judiciary, they have the medication[494].

In this section I addressed how trust factors in litigant's decision to start legal action, and how it is affected by the litigation's outcome. However, the trust in the outcome of the litigation, or the understanding of the relevance of the claim, does not necessarily refer to

[493] Interviewee 46 (2017) Interview with public defender in Florianópolis (SC) [02/02/2017]

[494] Interviewee 52 (2017) Interview with representative of pharmaceutical companies' association in São Paulo [09/02/2017]

litigants' normative assessment about the correctness of health care litigation as a sociological phenomenon. Moreover, according to one litigant:

> I think it is wrong [to have to start a lawsuit to get access to drugs] but people are not able to access anything they need today. It is very difficult for people to choose from what is right and what is wrong. Think about someone who need a tomography that costs up to R$8,000 (…) and that person earns a minimum wage. How is this person going to get a scan like that? (S)he will have to resort to the Judiciary[495].

Can health care litigation then be understood as an expression of the litigant's citizenship? Or is it merely about a utilitarian way around (*jeitinho*) the failed bureaucracy of the Brazilian State? These are the questions addressed in the next section.

6.5 Exercising citizenship through litigation? - legal consciousness about the right to health care in Brazil

As explored in Chapter 2, since colonial times the limits of what is right and what is wrong in Brazil are blurred. In a country strongly shaped by private interests, where the powerful cannot be trusted, citizens need to find a way, a *jeitinho*, to enforce their rights. If litigation is the way, then even if morally wrong or an inefficient form of advancing the collective interested, it will be the chosen path. This relationship with the law is framed by Ewick and Silbey[496] as a "with the law" legal consciousness – a view of the law as a game-like, tactical way of manoeuvring the legal system. Beyond that utilitarian, "with the law" form of legal consciousness described by litigants, I also wanted to explore more how (and if) litigants understand health care litigation operates as part of a wider political phenomenon, whereby citizenship is exercised via legal action. Or is it merely the commodified way of a consumer-citizen accessing a public good?

[495] Interviewee 23 (2016) Interview with litigant in Campinas (SP) [12/12/2016]

[496] EWICK and SILBEY, *The Commonplace of law. Stories of everyday Life*

In 1966, Carlin et al. described the legally competent person as someone who is aware and assertive about their sense of rights possession and sees the legal system as way to validate those rights[497]. The manner in which the legal competence is then manifested and exercised reflects how someone interprets the law and the possibilities for legal agency. In other words, their legal consciousness. Thus, how people frame their rights and how they act - or not act - about it is an essential part of understanding how the law operates in a society and how the formal law (otherwise known as law in the books) relates to the social practices (or law in action).

In the case of health care litigation in Brazil, unpacking the litigant's legal consciousness and legal competence is necessary to further understand the socio-legal factors that underline the rise of individual lawsuits. Furthermore, analysing how someone's legal consciousness is expressed also sheds light on wider dimensions of the social and political fabric of a society.

In the case of Brazil, the way litigants framed their rights and their decision to start legal action individually to access a drug or treatment not covered by the public health care care can be associated to various cultural traits explored in this thesis, which do not necessarily relate to legal issues. In this section I explore how litigant's legal consciousness about the right to health care informs a wider understanding of citizenship and how the relationships between citizens and the public sphere are established in Brazil.

During their interviews, all eleven litigants expressed in some way a strong belief in their *individual* right to access the drug or treatment, either via public policy or through

[497] SILBEY, 'After legal consciousness'

litigation. Even if some[498] occasionally pointed to negative systemic impacts of health care litigation on the public policy, still all litigants were firm to express confidence in their right to access a drug or treatment needed – even if not included in the health care policy or approved by ANVISA (the health and safety agency). Nonetheless, very few litigants used formal legal terms to describe their right, as the table below illustrates[499]:

Table 4: Frequency of usage of Legal Terms in Litigant's Interviews

	Right(s)	Right to health	Right to life	Fundamental right(s)	Constitution or Constitutional	Tax	Duty or Duties	Corruption	Citizenship	Society
Win. Litigant 1	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Win. Litigant 2	Yes	No	No	No	No	Yes	No	Yes	No	No
Win. Litigant 3	No	No	No	No	No	No	No	Yes	No	No
Wing. Litigant 4	Yes	No	No	No	No	No	No	Yes	No	No
Win. Litigant 5	Yes	No	No	No	No	No	No	Yes	No	No
Win. Litigant 6	No	No	No	No	No	Yes	No	Yes	No	No
Win. Litigant 7	Yes	Yes	No	No	Yes	No	No	Yes	No	Yes
Win. Litigant 8	No	No	No	No	No	Yes	No	No	No	No
Loosing Litigant 1	No	No	No	No	No	No	No	No	No	No
Loosing Litigant 2	No	No	No	No	No	No	No	Yes	No	No
Loosing. Litigant 3	Yes	Yes	No	No	No	No	No	Yes	No	No
Total (11)	**6/11**	**3/11**	**1/11**	**1/11**	**2/11**	**4/11**	**1/11**	**8/11**	**1/11**	**2/11**

What the table above shows is that even though all eleven litigants in some way defended their right to start a legal action in order to get access to a drug or treatment not provided for in the public system, very few of them referred specifically to the legal terms. The terms most frequently used were rights, generally conveyed, and corruption. By generally I

[498] Four out of the eleven litigants made a spontaneous remark about finding the health care litigation as a phenomenon wrong and detrimental the system. However, none of them related such remark to a feeling of wrongfulness in their decision to start legal action.

[499] This table shows the voluntary and explicit usage of legal terms by the interviewed litigants. It does not represent situations in which it could be interpreted from the context that they referred to a legal term.

mean that when talking about his/her *right(s)* the interviewed did not specify which rights (s)he was referring to. Also, in eight out of the eleven interviews, litigants referred to health without talking specifically about the constitutional right to health care, which can be attributed to a vague consciousness about the right, but no specific knowledge of the legal system.

It is interesting to observe that all of these interviewees went through legal procedures, and most were victorious (8/11). However, even so, there does not seem to be an in-depth understanding of the formal law. Moreover, only one litigant talked about the Constitution, the fundamental right to health care, right to life and about the duties of the State and the citizen. This litigant also talked about how the Judiciary as the only way through which societal change can be achieved in Brazil. (S)he is from São Paulo and started legal action to have her/his right to plant medicinal marijuana declared by the State, preventing future criminal prosecution. After three attempts, represented by an activist lawyer who acted pro-bono, C. was able to get a judicial declaration acknowledging her/his right to plant the medicinal marijuana at home. Reflecting on how (s)he perceived the legal process and how it affected her/him as a citizen, C. says:

> I think that [social change] must go through the Judiciary, but for that, more patients must come together to enforce their rights in courts. I have already tried to reach ANVISA, the Senate, the media, everyone. (…) On all fronts, the Judiciary gave me relief. And it must be there, in the first degree, because there you can reach the judge who is impartial, who is not yet at the Superior or Supreme Court of Justice, infiltrated in corruption. These Justices suffer so much political pressure. The people like us, from below, when our claims arrive on the first instance judge, who is also a father or a mother, he/she looks at the people's needs without the corruption of capitalism, understand? (…) This experience in the Judiciary helped me a lot. (…) When I won it got clear that people really have this strength. I was exercising my rights. The right to life is fundamental, it is paramount[500].

[500] Interviewee 51 (2017) Interview with litigant from São Paulo [09/02/2017]

Besides talking about her/his perception that the Judiciary is the only avenue for social change and fulfilment of rights in Brazil, C. also expressed a sense of empowerment through the judicial process. Not only personal empowerment, but a feeling that through lawsuits, litigants are able to achieve the changes which they could not do elsewhere. C. is not related to the legal profession but has been an activist for the right to cultivate medicinal marijuana for several years. Through her/his advocacy activities (s)he had contact with ANVISA, several legislators and worked closely with lawyers to educate the population, politicians and judges about medicinal marijuana.

Through her/his active participation in the legal process and advocacy of a right to plant medicinal marijuana, C. developed a deep understanding of the formal law, and the political process. The other litigants, albeit also participating in a lawsuit, describe their relationship with the process from a distant/observant angle. These litigants would merely follow the physicians' advice to search for a lawyer and start legal claim, then put together the documents required by the attorney or public defender and wait for the result. Once granted the decision, they could pick up the drug from the public pharmacy. This step-by-step procedure was the only detailed description offered by the other litigants. As spectators of the legal process, litigants did not reflect about their rights, about the consequences of the litigation and about their citizenship, like C. The Judiciary was, for them, another pharmacy counter where it was easier to get the medication than elsewhere.

> What happens is that it is easier to sue. Is near your home, right, the party goes after what is more accessible. (…) They will then seek the Judiciary and are using two constitutional guarantees of the utmost power, the fundamental right to health, which is the result of the right to life and the fundamental right of access to justice. These are two fundamental rights of the highest carat in our Constitution.[501]

[501] Interviewee 29 (2017) Interview with prosecutor in São Paulo (SP) [12/01/2017]

After corruption and *rights* the most used legal term during interviews was "taxes". When referring to taxes litigants usually talked about their right to access the drug or treatment needed in light of the taxes they paid and the fact that the State did not offer good public services in return. This observation very often related to a perception of corruption and inefficiency of the State.

> The State is the one that, according to the Constitution, must guarantee health care for the population. But we don't trust the government today – there is a total robbery [of the public money]. Imagine if I didn't ask for the insulin pump. This money would be turned into a necklace for Sérgio Cabral's wife [referring to the former governor of Rio de Janeiro who was arrested for corruption]. The pump would become another ring, so I would rather have the pump than give him having the ring. This is horrible, you know, claiming that I want better treatment because of corruption. But health cannot be a seen as a privilege. It is a right. We deserve to have quality of life; it is not a luxury[502].

Another passage from the interview with a Public Attorney from the state of São Paulo illustrates this rationale. (S)he recalls a lawsuit in which the claimant asked for a long list of medications, many of which already available in the health care system and the public pharmacies:

> There was a litigant once in the federal court who filed a lawsuit asking for a very list of drugs. During the hearing [the State's defence] explained that most of what she was asking for was already available in the public pharmacies, either in the specialised medication pharmacy or in a regular public pharmacy (…). She then replied: "But son, these pharmacies you talk about are all distant places, I need to walk so much to reach them. If I win a lawsuit, I will be able to get it all from one place". I then told her, yes, however Mam, you are imposing an expenditure for the State when we can already provide the drugs you are requesting. [She replied] "Yes, but I pay my taxes, right?"[503]

This quote illustrates how the litigant's consciousness of their right to access the drug or treatment via courts is directly related to the fact that they pay taxes and are therefore entitled

[502] Interviewee 20 (2016) Interview with litigant in Rio de Janeiro (RJ) [09/12/2016]

[503] Interviewee 28 (2017) Interview with public attorney for the Secretary of Health in São Paulo (SP) [12/01/2017]

to the best product for their need in the most convenient manner – as if they were purchasing a good.

In conclusion, the way litigants described their right to access health care via courts did not thus derive from an understanding of litigation as a tool of citizenship and civil activism. Rather, legal action is understood as means for obtaining a good (commodification). Indirectly, litigation also serves as reparation from an otherwise [perceived] absent State. In other words, the State's duty to provide the medication requested, even when excluded from the public policy, arises from an indemnification for the corruption and inefficiency observed in the government in general. A quid pro quo equilibrium.

6.5 Conclusion

> I never had a case that [the Court] denied the request for *justiça gratúita* [court fee remission]. I have always won 100% of the requests. So here in Santa Catarina [court fees remission] is a problem, I think. Because the court lacks criteria of when to give it. (…) I had a funny case of a client, a taxi driver, who caught my attention because the medicine he was asking for was very cheap. It costed something like R$9 [circa £1.5]. Why go to court because of a R$9 drug? I thought. Then, when he arrived here, I asked: are you unable to buy a R$9 drug? He replied: no, I have [the money to buy it], but it is my right and I want to go to court. So, sometimes I say that if litigating costed R$100, many people would decide not to. They do it because it is free. (…) In another case, a lady came to me and said: "I needed an antibiotic". Okay, I said, can I have the prescription? She replied: "No, I need you to give me an antibiotic". But I am not a doctor, I replied. She wanted me to prescribe an antibiotic. So, I told her: "I'm not a doctor, I'm a public defender, I'm a lawyer, I can't prescribe medication". She waited for days in a queue to be able to speak to a public defender without a case. Instead of going to the doctor she came to the public defender's office.[504]

The massification of individual health care litigation in Brazil is a by-product of a web of socio-legal factors that has judges and litigants as its central actors. A litigant's decision to start legal action against the State for access to health care is influenced by both structural (external) and personal (internal) factors, which reinforce one-another. On the one hand, the

[504] Interviewee 46 (2017) Interview with public defender in Florianópolis (SC) [02/02/2017]

1988 Constitution established a legal framework of wide social-economic guarantees and ample access to courts. The investment in a strong legal aid system, coupled with an extensive legal interpretation of the concept of "access to justice", produced a litigation fever which today overloads the judicial system and trivialises legal action (as the quote of the public defender above illustrates). In the context of a post-colonial society, marked by deep inequalities and high levels of corruption within the public sector, individual litigation is often perceived as the only way around the systemic problems (a quick-fix and a *jeitinho*). Under these conditions, the relationship of citizens with the State, including the health care and judicial systems, becomes commodified. The inability to (easily) access a health service or device is considered as a breach of the contractual relationship established between the clients (citizens), who pay for the service with their taxes, and the government. Litigation then becomes the only perceived route to get easier (and cheaper) access the health products which would otherwise be too expensive or hard to get.

On the other hand, litigants place a utilitarian trust in courts (often referred to as trust in the judge) to grant the legal claims and enforce their constitutional right to health care, which is reinforced by the high success rates. The decision to start legal action is thus mostly a calculative and utilitarian decision which takes into consideration the probability of success and costs. However, although most litigants do not consider litigation as a tool for exercising citizenship – i.e., as a means for civil activism, legal action is still a way to be heard by the otherwise absent State.

The context of a litigation fever in health care litigation is then further incentivised by third parties' private interests, such as pharmaceutical companies and patient's association, who identify in individual litigation an opportunity to 'take a bite of the State at the expenses of judge's good-will'[505], as a civil servant from ANVISA points out. The role of the third

[505] Interviewee 54 (2017) Interview with public lawyer for ANVISA in Brasília (DF) [07/06/2017]

parties in influencing the massification of health care litigation in Brazil is the topic analysed in the next Chapter.

CHAPTER 7 - BACKSEAT DRIVING: THIRD PARTIES' ROLE IN THE MASSIFICATION OF HEALTH CARE LITIGATION IN BRAZIL

> There are public hospital service desks that have glued to the counter a paper with the public defender's office address. So, when patients are denied a treatment or a drug, they ask the hospital staff what to do and their answer is 'you have to look for your rights'[506].

In the last chapter I explored the factors influencing litigants' decision to start legal action. As I identify litigants and judges as the main actors of mass health care litigation, other actors involved in the litigation, either directly or indirectly, are considered for their influence in litigation as external factors. In this chapter I analyse who are the key "third party" actors, and to what extent they influence the increase in health care litigation. Furthermore, I explore how the interest and influence of these third parties fits into the wider context of individualism and commodification of health care and access to courts discussed in the previous chapter.

Although there are a number of third parties who can be considered to indirectly influence the increase of successful health care litigation, such as prosecutor's and civil servants of the health care system (i.e., ANVISA and CONITEC), in this chapter I focus on medical doctors, patient's associations and pharmaceutical companies. The reason for such choice is that these actors have an important, albeit indirect role to play in the massification of health care litigation. As I explain throughout this chapter, these actors are key in bringing information to litigants and often enabling litigation via legal assistance and indirect funding offered by NGOs (who in turn are funded by pharmaceutical companies). They are not, however, formal actors in the litigation or policy making, which makes their influence in health care litigation harder to identify and unpack.

[506] Interviewee 7 (2016) Interview with a public defender in Brasília (DF) [18/11/2016]

In the last chapter I addressed how the multiplication of litigation, also referred to in the literature as judicialisation of life[507] or litigation fever[508], is a product of a structure of litigation incentives which facilitates access to court – often incorrectly read as access to justice[509]. However, it is also this structure which incentivised the direct or indirect (ab)uses of the judicial system by repetitive players and third-party economic interests. In this chapter I explored how the litigation system in Brazil is used by third parties who benefit economically from it, and how these actors influence the rise of successful health care litigation.

7.1. The role of medical doctors as influencing the rise in successful health care litigation claims in Brazil

The first important role these third parties play in health care litigation is raising awareness about litigation for access to drugs, treatments and medical devices. Moreover, access to justice starts with awareness[510]. Not only about the existence of rights and their exercise, but also about the possibility of exercising them, and the legal avenues necessary to do so. Navigating the legal roads of litigation is not easy, which is why third parties, such as private attorneys and public defenders, play such an important role in helping people make their decision to start legal action. In the context of health care litigation in Brazil, however, this is not the whole picture. Even though legal representation is indispensable for the great majority of claims – excluding those filed before the smalls claims court under R$20,000, as explained in the previous chapters – lawyers are not the only (or main) actors pushing patients towards health care litigation. Before ever reaching the lawyers and public defenders, litigants

[507] Luís Roberto BARROSO, 'Countermajoritarian, Representative, and Enlightened: The Roles of Constitutional Courts in Democracies' (2019) 67 The American Journal of Comparative Law 109
[508] WOODS, 'Litigation fever'
[509] Deborah L RHODE, *Access to justice* (Oxford University Press 2004)

[510] Teresa MARCHIORI, 'A Framework for Measuring Access to Justice Including Specific Challenges Facing Women' (2015) Recuperado de https://rm coe int/1680593e83

learn about the possibility of starting legal action through their physicians, who also often connect them to legal representation and provide all documentation needed to support the legal claim.

From the eleven litigants interviewed, five learned through their medical doctors that they could start a lawsuit against the State to get access to the medication prescribed. Two were sent by their physician to a patient's association, which then advised them about the legal process to start litigation; two learned about the possibility – and probability – of getting access to drugs through litigation via Facebook group; and the last one was advised by an employee of the Health care Secretary which informed her/him that (s)he 'could only get the drug in court'[511]. Besides the accounts of litigants' themselves, the private attorneys and public defenders interviewed also talked about the importance of the 'word of mouth' and the central role of medical doctors in incentivising litigation.

Although the interviews are not enough to quantitatively determine where litigants mainly receive the information about litigation, they indicate the importance of medical doctors as agents of the judicialisation of access to health care. Physicians were the main source of information mentioned not only by litigants but by all of the private attorneys, public defenders, prosecutors, and judges I interviewed. Not only that, but medical doctors were also described as playing a key role in connecting the litigant to the lawyer or to the association which then took care of the legal representation. For example, when asked where (s)he found the attorney who represented her/his claim, one litigant says that 'my doctor has a lawyer that starts cases in court for her'[512]. Another litigant, A., who suffers from amyotrophic lateral sclerosis (ALS), explained how her physician and the pharmaceutical company offered all the information needed to start legal action:

[511] Interviewee 47 (2017) Interview with litigant from Campinas (SP) [03/02/2017].

[512] Interviewee 25 (2016) Interview with litigant in São Paulo (SP) [15/12/2016]

> I did not really think about [not starting the legal action], because I blindly trust my doctor and she told me that I needed this new medication and that the easiest way to get it was via courts. (…) My doctor informed me about the possibility of litigation and told me that I should register at the laboratory [that manufactures the drug] before starting the legal procedure. (…) I had to register with the laboratory (…) so they could track my case. (…) When I contacted them what they said that they would give the medication until I got it through court. So, for about four months they gave me the medication for free. (…) Every month they would ask me how I was doing, what was the status of my lawsuit. (…) My doctor gave me the contact to one lawyer, the laboratory suggested another one, but I ended up choosing a friend of my mother's [who is also a lawyer]. This lawyer called another attorney from her law firm who had already started several other health care lawsuits. (…) He mentioned that here in Campinas there are many people litigating for this medicine (…) and that I would win for sure. I paid him R$4,000 [circa £800]. (…) it is a lot of money, but my parents said they would help me, so I was able to afford it. (…) The whole procedure took around 4 months[513].

The quote from A's interview, transcribed above, accounts for the importance of two actors in her/his decision to start legal action. Firstly, the medical doctors, who (s)he claims to trust "blindly" and said litigation was the easiest way to access the medication (s)he needed. Then, the pharmaceutical company offered assistance towards finding legal representation and offered the drug for free until (s)he "got it via courts".

According to five litigants, their physicians, both from the private and public system, recommended starting litigation as a 'normal' path to getting access to a drug not available in SUS. Even when an alternative medication was available through the public health care protocol and could therefore be accessed in public pharmacies, medical doctors would still prescribe other drugs and advise their patients about the possibility of getting them via courts. Furthermore, often these doctors would suggest a lawyer or refer them to the public defender's office, as one public defender from Rio de Janeiro describes:

> Most people learn [that they can judicialise] through their doctor, and most of the claims we start are from SUS patients. The majority of litigants that come to us were referred

[513] Interviewee 23 (2016) Interview with litigant in Campinas (SP) [12/12/2016]

> by doctors from the public health care system: from the family clinic, from public hospitals... What I also see a lot is that doctors are not aware of the clinical protocols. They often work in a private practice and for the SUS, so they repeat in the public system what they do in the private practice. Sometimes they get a free sample of a medicine from the pharmaceutical company, so they prescribe it even if it is not in the protocol. Because they are not aware of the clinical protocols of the Rename [federal list of medication], the Remune from their municipality [municipal list of medication][514].

According to the public defender from Rio, physicians do not follow the public protocols set up by the health care authorities, either because they are not aware of it, or because they chose not to follow it. For the defender, medical doctors repeat in the public surgeries what they do in their private clinics. However, according to a medical doctor from São Paulo[515] who practices both in private and public clinics, prescribing a drug which is not included in the SUS protocols was not about lack of knowledge about the policy. The reason behind his choice to prescribe drugs not covered by the health care system lies in his belief that a medical doctor's ethical role is to prescribe what is best for the patient, even if that means prescribing a medication that is not part of the health care public policy. According to him/her, advising patients to litigate had to do with getting access to best medical technology – in his/her case hearing aids:

> [E]veryone has the right to hear. (…) And I want what is best for my patient. I want him/her to get access to this hearing aid because I know it works.[516]

Another medical doctor, who had also been involved in the policy making process in the state of São Paulo, describes physicians' behaviour in relation to litigation as largely responsible for the massification of legal claims:

[514] Interviewee 21 (2016) Interview with public defender in Rio de Janeiro (RJ) [09/12/2016]

[515] Interviewee 37 (2017) Interview with medical doctor in São Paulo (SP) [22/01/2017]

[516] Ibid

> I think the doctor is largely responsible for initiating this process [of litigation]. You know, the doctor can sometimes be moved by a belief that a particular drug is really important for the patient. At other times, he is driven by different interests, including economic interests [referring to doctors who are paid by the pharmaceutical companies to prescribe their medications]. (…) There are requests for drugs, orthoses and prostheses [in the Judiciary] that have much cheaper equivalents in the public system. [One example] are the drugs for cancer treatment that, according to the literature, prolong life. Sometimes, only for a week. The public system will pay a drug that costs R$150,000 (circa £20,000) to prolong the life of a cancer patient for one week or one month. I mean, there is no rationality in that. The only interest protected there is the economic interest, it does not bring any real benefit to the patient, sometimes it ends up only prolonging the suffering of that patient, the family[517].

The commodification of health care[518] and individualism which drives the litigants' choices, explained in the previous Chapter 6, is therefore an important factor influencing the decisions of medical doctors as well. Moreover, medical doctors in Brazil opt to encourage their patients to start litigation against the State in order to ensure the usage of a drug they think is best, even in cases where there is an alternative in the public system. In this case, physicians, who also relate to the health care system in a consumerist manner, put the wellbeing of one patient and his/her personal opinion above the collective interest denoted in the public policy. In this way, the behaviour of physician can be compared to the behaviour of judges as individuals who believe they are responsible for the wellbeing of patients/litigants. In both cases, there is a personal empowerment and a belief that their expertise and sense of righteousness is the best for the patient/litigant involved.

Beyond the sense of personal responsibility of the patient/litigant's wellbeing and personal empowerment to positively affect their lives, both judges and physicians expressed a

[517] Interviewee 31 (2017) Interview with medical doctor and former civil servant of the Secretary of Health care in São Paulo (SP) [12/01/2017]

[518] As explained before, in chapters 1 and 7, commodification of health care is the process through which individuals perceive health as a good and themselves as consumers. As such, individuals require access to the 'best available' health technology, which is an approach often also adopted by physicians (Saras HENDERSON and Alan R PETERSEN, *Consuming health: The commodification of health care* (Psychology Press 2002))

distrust in the public policy and the policy-makers, which was then used as a reason to undermine it and impose their personal solutions. Judges relied on the Constitutional right of universal health care as the formal reasoning to supporting their decisions, while physicians talked about their ethical duty to give their patient the best treatment possible. And, in both cases, the symbolic moral weight of their professions underlined their sense of duty to act in favour of the patient or litigant.

> The doctor does not have awareness [about his impact in the public policy], because this is not taught to think collectively in medical school. (...) The physician does not have consciousness about the public interest, which is the big problem. The way physicians act is very individualistic. (…) Then talking about trust, there is also a distrust of the medical doctors in the public [health care] protocols. […] And sometimes I even think that there is a component of the doctor's ego: they want the best treatment for their patient[519].

In a similar way, a Prosecutor from São Paulo comments on the similarities between the behaviours of physicians and judges:

> Doctors and judges are two groups that are not used to hearing the other side. The prosecutor is a little more used to hearing the other side. (…) So, doctors are the same as judges, they have very strong personal beliefs. So sometimes the doctor says: 'I prescribe medicine x for this disease.' Then the SUS representative suggests a therapeutic alternative and the doctor replies: 'but I prescribe the other one. This drug [suggested by SUS] I do not know, I do not know if it works, and I am not obliged to know or to prescribe it.' So, I mean, both the doctor and the judge occupy very similar positions, which are quite powerful. In these cases, the individual interest disregards a more systemic solution[520].

The importance of physicians in the health care litigation phenomenon, mentioned by the prosecutor, goes beyond their influence in deciding which drug and treatment to prescribe, or even suggesting the start of legal action for access to a medical device. The technical

[519] Interviewee 41 (2017) Interview with representative of a pharmaceutical company in São Paulo (SP) [26/01/2017]

[520] Interviewee 29 (2017) Interview with prosecutor in São Paulo (SP) [12/01/2017]

knowledge of physicians also works as a shield for judges, who claim they cannot refute the technical decision of someone's personal doctor. As analysed in Chapter 5, the medical prescription is often used as the sole piece of evidence to prove the litigant's need to a particular drug discussed in litigation. Interestingly, however, the technical deference shown by judges to the physicians prescribing the drug requested by a litigant is not extended to the technicians behind the health public policy (and the State's defence lawyers). By distrusting and disregarding the quality of politics and of the government as a whole, judges decide beforehand to disregard the technical knowledge of policy makers, accepting the knowledge of personal physicians, even when these doctors are not from the public system.

> It does not mean that I blindly grant the medicine because the doctor is asking for it. I analyse it, check it. There must be a diagnostic supporting the request. But other than that, I cannot discuss the doctor's instructions. I cannot discuss the medicine's leaflet with the doctor. This is not for the judge to do[521].

The same rationale according to which medical doctors are the ones best equipped to decide a patient's medication was also expressed by prosecutors, who used the technical decision of the physician as a justification to support[522] the decision which grants a drug not covered by the public policy in the system:

> There is no way [to be against the claim] because this decision is not of the Prosecutor's Office, this decision is the doctor's. This is a judgment that completely escapes our attributions. The other day a prosecutor called me and said: look, I have a request from a person that has 94 years old and is asking for a medicine that costs R$100,000 (circa £20,000) per month. He sued a tiny municipality, which has only 2,000 inhabitants, and it will have to spend R$100,000 per month because of a patient who is already 94 years old… What I replied was that this assessment was not ours to make, it is not the prosecutor who will say whether this person deservers the drug or not... The doctor is the one who must say what their patient needs. And if this is the doctor's decision [to prescribe the expensive drug], then we will support the concession in the lawsuit. This

[521] Interviewee 32 (2017) Interview with first-degree judge in Campinas (SP) [16/01/2017]

[522] In some cases, prosecutors are called to manifest their interpretation of the law in the litigation as representatives of the public interest.

> tragic choice is not ours to make, our role is to defend the legality of the public policy. It is to curb illegalities. Yes, we have to try to reduce the injustices that the health care litigation phenomenon has generated, but I don't think it is possible to close the doors of the Judiciary. Our position is very firm, there are two fundamental rights that we will defend until our death: people will go to court because it is a fundamental right [to access justice and health care][523].

By attributing to the physician the responsibility of making the decision of which drug or treatment to prescribe the actors in the judicial system – judges, prosecutors, public defenders, and private attorneys – separate the central matter of health from legal responses to it and shift the focus of the problem from the courts to the health care system itself (i.e. instead of training the spotlight on judges being responsible for incentivising the increase of health care litigation by granting claims, medical doctors become the scape goats for driving health care litigation when prescribing medication and treatments not included in the public system[524]). The reality, however, as I explain throughout this thesis, is that health care litigation is a complex socio-legal phenomenon with several interrelated factors and actors influencing it. Medical doctors and judges are two important actors of such a web.

Thus, according to the rationale which puts medical doctors as central to the health care litigation phenomenon, physicians are the only ones responsible for evaluating the necessity of a particular treatment, which is then considered as encompassed by the constitutional right to health care –interpreted as an individual right and commodified. Once the drug, treatment or medical device is prescribed by a medical doctor then a person's right to get it is born under the universal right to health care provided for in article 196 of the Constitution. Litigation thus becomes a normal part of the public health care system. It is another ordinary route to realise the constitutional right to health care. It is a *jeitinho,* a way around the perceived inequalities, deficiencies of the public service and perceived injustices in the access to health care.

[523] Interviewee 29 (2017) Interview with prosecutor in São Paulo (SP) [12/01/2017]

[524] For example, Interviewee 8 (2016) Interview with judge from the Superior Court of Justice in Brasília (DF) [18/11/2016]

Beyond the individualism identified in the actions of litigants, and in the commodification of health care, the lack of a self-accountability for contributing to a problematic situation of repetitive litigations that flood the Judiciary and create challenges for the public health care budget can also be understood as an individualistic behaviour from medical doctors. The responsibility for the challenges which arise from a mass repetitive health care litigation are often attributed to other actors, as if people's own actions were not part of the problematic phenomenon – i.e., medical doctors attribute to lawyers and judges the responsibility of incentivising health care litigation[525], whilst judges[526] and lawyers[527] often attribute such responsibility to the medical doctor. And both justify their actions in the context of a distrusted public policy.

This individualism and commodification of health care litigation is even more prominent when private interests are involved. When the access to drugs and treatments are judicialised, the beneficiaries are not only the patient and their attorneys. The pharmaceutical industry is another important – and often hidden – interest behind the multiplication of health care lawsuits, a point further discussed in the next section.

7.2 Third private interests in health care litigation: how pharmaceutical companies and patient's associations benefit from individual legal action

> We charge based on the outcome of litigation. We charge 20% of the economic result involved in the claim. We choose to do this because the client is going through a medical problem, (s)he is seeking a medication through legal action, so I will not charge him. I will only charge him if I am successful. If we get the injunction, we charge. This strategy is worth it because we have around 92% success rate.[528]

[525] Interviewee 37 (2017) Interview with medical doctor from SUS in São Paulo (SP) [22/01/2017]

[526] Interviewee 26 (2016) Interview with first-degree judge in São Paulo (SP) [21/12/2016]

[527] Interviewee 21 (2016) Interview with public defender in Rio de Janeiro (RJ) [09/12/2016]

[528] Interviewee 13 (2016) Interview with private attorney specialised in health law in São Paulo (SP) [24/11/2016]

I interviewed the lawyer above quoted in his/her office, inside one of the most expensive business streets of São Paulo. His firm only represents cases involving health care law and most of his work comprises of lawsuits for access to drugs and treatment, either filed against the State or health insurance companies. The no-win, no-fee strategy described by the lawyer as form of attracting litigants is not exclusive to the Brazilian system. In fact, the conditional fee – or contingency fee in the US - charging is considered one of the most important reasons behind the increase in litigation in the UK and the USA[529], for example. And for that reason, policy makers debate restraining the possibilities of no-win, no-fee services to curb litigation in society[530].

Aside from the specialised lawyers who offer the no-win, no-fee charge, and the public defender's office, which provides free legal aid to underprivileged citizens, there is also a powerful industry that is willing to pay for litigant's fee in exchange of making sure the State is obliged by a judicial decision to buy their drug. Some patients receive direct help from the pharmaceutical industry to litigate. For instance, the ALS patient from Campinas, A., quoted in Chapter 6, received the expensive drug for free from the pharmaceutical company, while (s)he waited for the lawsuit to be finished.

> When [the pharmaceutical companies] finishes the clinical research, they already have a lawyer, an industry entirely organised to sell drugs via judicialisation. The patient's associations - and if you enter the patient association websites, they are all sponsored by the industry – they already have a lawyer ready to sponsor the litigation. So, it is very easy. The patient just needs to sign the power of attorney. The very proactive associations search for patients. When it is a rare disease, for example, they go after the sick and judicialise their cases. Brazil is very large; it is a very important market. For example, we did an analysis, at Rename [the national list of drugs available at SUS] there is no medication for otitis. And children have otitis all the time. We conducted an evaluation to include a cheap medicine [for otitis], that costs pennies, which is included in the national protocols [of SUS]. How many people came in to contribute to the public consultation? Four people. Now we are doing the same consultation for multiple

[529] Paul FENN, Veronica GREMBI and Neil RICKMAN, ''No Win, No Fee', Cost-shifting and the Costs of Civil Litigation: A Natural Experiment' (2017) 127 The Economic Journal F142.

[530] Frank FUREDI and Jennie BRISTOW, *The social cost of litigation* (Centre for Policy Studies 2012)

> sclerosis drugs. There are more contributions than the number of patients. So, [the conclusion is that] nobody cares about cheap medications. They are only interested in what is expensive. Because there is a whole industry behind. If you go to the association website, sometimes they even have the phrases ready for the people to include in the consultation: "Go to CONITEC's consultancy website and write this and this". Then sometimes we see that 100 people wrote the same thing in the consultation. Copy and paste[531].

The CONITEC officers account quoted above describes an organised machinery that feeds from the judicialisation of health care for private gain. This system is only possible due to the high-volume of cases filed, tried, and ruled successfully in Brazilian courts, and it thus requires that all actors involved in the litigation have coordinating behaviours. In other words, for the litigation machinery to work, it needs to offer strong incentives for patients to start litigation, doctors to support the claims, lawyers to represent the patients and for judges to grant the requests. Aside from judges, whose independent behaviour is analysed in Chapters 3 and 4, the other actors' interests can be aligned and influenced by the pharmaceutical industry. Moreover, as the officer of CONITEC describes, the pharmaceutical industry funds NGOs, which then seek medical doctors to identify patients with the disease they represent and offer free legal services. Patients are then contacted or told by the doctor to contact the association – often via telephone, avoiding expensive trips – which tell them that they are only requested to sign a Power of Attorney giving the association's lawyer the power to represent their claim. The litigant then just needs to wait, and, if the claim is successful, collect the medication in a specialised pharmacy – which sometimes offers an exclusive counter for patients armed with judicial decisions. Litigants, such as two[532] of the ones I interviewed never even meet the lawyer, go to the association or have an in-person hearing with the judge.

[531] Interviewee 48 (2017) Interview with civil servant of CONITEC in Brasília (DF) [06/02/2017]

[532] Interviewee 5 (2016) Interview with litigant in Brasília (DF) [17/11/2016] and Interviewee 9 (2016) Interview with litigant in Guarulhos (SP) [21/11/2016].

These NGOs are usually disease specific associations whose job is to advocate for the patient's interest and who also offer free legal service, including any incurring legal fees, for health care litigation. These associations are often funded through the donations of pharmaceutical companies.

> These associations are usually funded by the pharmaceutical industry. Or by drug distributors. That is the problem. So, thanks to the fragility of our legal system and of the Executive, due to this very favourable environment, we observed the development of a judicialisation industry, were many people win. Lawyers win, doctors win and no doubt that the industry profits the most from this. But there are also organised gangs that profit from the judicialisation, and sometimes the patient really becomes the victim. The patients end up receiving a drug that has no indication for their illness (…). Medicines that could be replaced by much cheaper equivalents. I would say that this judicialisation does not bring benefits to the large community.[533]

From the individualistic angle, *almost* everyone benefits from this scheme: patients can access the medication or treatment they need, doctors are able to prescribe the best treatment for their patients, lawyers are paid, patient's associations get their funding, and the pharmaceutical companies sell their drugs to the State for market price, without having to go through the bureaucratic and slow procedure at ANVISA and CONITEC. The losing side? The Brazilian State, the health care system and all other patients of the public system who now share an underfunded SUS or are sent to the back of queues and cannot get access to the same drugs, unless via litigation.

The use of the judicial system through health care litigation by pharmaceutical companies and other economic interests comes across in other findings of the literature, such as Chieffi and Barata[534], and Campos Neto et all[535]. In an empirical analysis of litigation filed

[533] Interviewee 31 (2017) Interview with medical doctor and former civil servant of the Secretary of Health care in São Paulo (SP) [12/01/2017]

[534] A. L. CHIEFFI and C. BARATA RDE, 'Legal suits: pharmaceutical industry strategies to introduce new drugs in the Brazilian public healthcare system' (2010) 44 Rev Saude Publica 421

[535] O. H. CAMPOS NETO, A. ACURCIO FDE, M. A. MACHADO *and others*, '[Doctors, lawyers and pharmaceutical industry on health lawsuits in Minas Gerais, Southeastern Brazil]' (2012) 46 Rev Saude Publica 784

between 1999 and 2009 in Minas Gerais, Campos Neto et all's findings reveal how repeat players and an organised structure involving a few doctors and lawyers abuse the system for private economic gain, impairing equity and favouring wealthier citizens. The authors highlight

> the association between doctors and law offices on drug requests. Among the lawsuits filed by the office A, 43.6% had a single prescriber to adalimumab, while 29 doctors were responsible for 40.2% of the same drug prescriptions. A single doctor was responsible for 16.5% of the adalimumab prescriptions, being requested through lawsuits filed by a single private law office in 44.8% of legal proceedings.[536]

It is important to point out, however, that this ethically questionable practice developed by the pharmaceutical companies to dodge the tight procedures of safety, efficiency and pricing of the Brazilian health care system are not used by all companies. As one representative of the industry affirms, 'serious' companies are not interested in fostering the industry of individual litigation in Brazil[537].

Nevertheless, the fact that the industry of health care litigation exists is a symptom of a system that is offering negative incentives and fostering more private exploitation of the public sphere (commodification). And while judges grant claims, patients will continue to file their individual lawsuits, reinforcing an individualist system which benefits the few who reach the courts, and the powerful private interests who exploit it.

> The patient, stimulated either by the doctor, or by the lawyer, or by these associations representing patients, is urged to take legal action in order to be able to have the medicine that doctor says is so valuable, so important to him/her. The patient does not have technical knowledge about that medicine, if it is really the most suitable for him, if there is an alternative that can serve him… Another problem that is also created by the way the health system works is that the health insurance companies do not provide the expensive medication. When these patients do not receive medication from the health insurance, they get it through SUS. (...) So, the way that our two systems work is one where the private parasites the public. For example, the patient needs an expensive cancer drug, the private system does not provide it, so (s)he requests it

[536] Ibid
[537] Interviewee 41 (2017) Interview with representative of a pharmaceutical company in São Paulo (SP) [26/01/2017].

> through the public system. And, often, this is a well-connected person. So, they end up getting treatment in the public system, leaving the person who has fewer personal contacts, less condition, less access, at the end of the queue[538].

The situation described by the interviewee above, a medical doctor who worked as high-rank public official at the São Paulo's Health Secretary, replicates the patrimonialism experienced since the times of colonial Brazil (analysed in Chapter 2), where the wealthy use their personal contacts and their economic or political power to get advantage of the public system (patrimonialism and clientelism).

> When the judicialisation came in, the industry had to do the math and, obviously, because the pharmaceutical industry is not an NGO, they concluded that if they wanted to offer the medicine in Brazil, it would be easier this way... I'll even give you an example: we have only one drug for rare disease which was incorporated in the public system by the CONITEC, so all the others have to go through judicialisation[539].

Medical doctors are also able to privately gain (financially) from health care litigation. According to a Public Prosecutor from Campinas, physicians have a lot of power to decide which drug or treatment a patient should use. If that physician is paid by the pharmaceutical company to prescribe a particular drug, then (s)he can join the scheme of private profit from health care litigation. In his/her words:

> Doctors can prescribe medications and treatments autonomously. This is provided for in rules of the Federal Council of Medicine. Well, (s)he can offer the drugs that are standardised, but what happens instead is that (s)he decides to prescribe another medication – not included in the protocols. We don't know to what extent that doctor believes in the efficacy of that drug or (s)he is prescribing it to be paid to attend the medical seminars in the USA, in Europe - all funded by the pharmaceutical laboratories. (…) [Health care litigation] also has its dark side. It is difficult to separate the chaff from the wheat. You don't know when the doctor is acting in good faith, according to his/her conscience, according to the research (s)he did or [pause referring to illicit

[538] Interviewee 31 (2017) Interview with medical doctor and former civil servant of the Secretary of Health care in São Paulo (SP) [12/01/2017]
[539] Interviewee 41 (2017) Interview with representative of a pharmaceutical company in São Paulo (SP) [26/01/2017]

> activities] … what happens is that many laboratories want to create demands to include the drug in the public system without having to go through the public procurement and pricing procedures. How can the industry introduce the drug directly in the market without going through the ANVISA procedure? Through judicialisation. Because the State is obliged by a judge to buy the drug at the market price[540].

Albeit not the rule, the actions of individual actors, incentivised by a powerful industry, form the bigger picture of health care litigation as a market. A complex web of actors and factors which goes beyond the simple enforcement of constitutionality or judicial review of administrative legality. It is impossible to understand the magnitude of the health care litigation phenomenon in Brazil without paying attention to all the sociological factors that work on the background. The different actors and drivers which incentivise the development of a market which in turn takes from the collective to give to the private. A phenomenon which favours individual answers to collective problems.

7.3 Undermining collectivism: why do Brazilians prefer individual litigation to multi-party litigation?

> The Constitution guarantees the universal access [to health care], but fulfilling this right is very difficult. I say that it there are two ways to manage the health system: you can manage it by providing health care to everyone or giving it only to those who ask for it. So, what happens today is that there is a constitutional right, but the government does prioritise offering [the drugs and treatments] in the public system. What they do is to give only to those who ask for it [via litigation] and save the money of those who do not ask – that is the mindset of the administrator[541].

According to a widely used idiom in Brazil, in times of shortage people act selfishly to protect their own private interests: *Farinha pouca, meu pirão primeiro* (When the flour is scarce, my broth comes first). The individualism expressed in the idiom, and identified within the context of health care litigation, also influences the choice of legal instruments chosen by

[540] Interviewee 34 (2017) Interview with public prosecutor from Campinas (SP) [16/01/2017]

[541] Interviewee 35 (2017) Interview with representative of a patients' association in São Paulo (SP) [17/01/2017]

lawyers, patients associations and litigants. Moreover, the massification of health care litigation is overwhelmingly done via individual legal action. In a quantitative analysis of health care litigation Brazil, Insper mapped the occurrence of collective claims (including the class actions started by the prosecutor's office) *vis a vis* individual claims and identified that in 2018 the first represent only 2,35% of the overall number of health care claims in the Brazilian Judiciary[542].

The reasons behind such choices encompass several different factors, which I address in this section. For instance, there is a wide *perception* that collective claims are less likely to be successful. A perception which does not necessarily find support in the numbers, according to Insper, but which does vary significantly in different regions. For instance, whilst in Para collective claims account for 25,66% of all health care litigation (in the Appellate Court), in São Paulo they only represent 2,86% and in Rio Grande do Sul, 0,44%[543]. This discrepancy could be due to a number of reasons which would require further investigations, however I can mention more active prosecutor's or public defender's offices, who would start collective claims, for instance.

Despite the regional differences, the predominance of individual claims in the health care litigation phenomenon still raises several legal and sociological questions. Even patients' associations, which should be guided by a collectivist rationale typical of civil society activism, display individualist discourses during their interviews. Instead of enabling a wider, more systemic discussion about the public policy, several associations prefer to resolve the individual problem of each patient via individual litigation. Other associations representatives mentioned not knowing that starting a collective claim would be an option.

[542] DE AZEVEDO, ABUJAMRA and ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução*

[543] Ibid

> Patient associations in Brazil are not strong, they are weak, they do not have this vision of really solving a problem, they are merely assistantship. So, they are concerned with getting a product for a patient. First, there is no effective control of the industry's relationship within these associations, so there are a lot of associations across the country that engage in unethical behaviours, which is the big problem. […][544].

The repeated choice for individual litigation puzzles the minds of lawyers and policy makers[545]. Why start individual legal action to enforce the realisation of a social right, which will have little impact on the policy itself? And why grant an individual request that will only benefit one litigant, when the requests for a medicine or treatment could be implemented through collective resolutions? Collective approaches strengthen the system and ensure that the solutions are enjoyed equally by all citizens through a policy change - not just the litigants who are able to access the legal system.

The answer to these questions would be easy if the Brazilian legal system did not have procedural provisions for collective litigation similar to class actions or aggregating solutions similar to bellwether cases. That is far from the case, however.

Since 1985, the Brazilian legal system offers multiple choices of collective actions aimed at enforcing different types of multi-party rights[546] – simplified as (i) diffuse, such as the right to a healthy environment; (ii) collective and indivisible, such as the rights of shareholders; or (iii) homogeneous individual rights, such as damages arising from a product liability.

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[544] Interviewee 10 (2016) Interview representative of a patient's association in São Paulo (SP) [23/11/2016]

[545] Felipe Rangel DE SOUZA MACHADO, 'Contribuições ao debate da judicialização da saúde no Brasil' (2008) 9 Revista de Direito Sanitário 73 ; and DE AZEVEDO, ABUJAMRA and ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução*

[546] The framework for collective litigation in Brazil was originally designed in 1985, with the instatement of the *Ação Civil Publica* – a representative action, whereby a legally designated plaintiff starts litigation against public or private bodies for the interest or protection of others, including the general public interest or specified groups of determined or undetermined individuals. With the enactment of the Consumer Code in the 1990s, individual claims with originated from the same fact were now able to be aggregated into one single, collective lawsuit." (Sérgio Pinheiro MARÇAL and Lucas Pinto SIMÃO, *Brazil* (The Class Action Law Review, 2nd ed, 2018))

In the case of health care litigation, collective claims could be of both the second and third type. For instance, patient's associations, prosecutors and public defenders are legally authorise to start a collective lawsuit (class action) against the State requesting the inclusion of a drug in the health care system that has been denied by the health authority.

As the literature points out[547], collectivising litigation would enable the representation of more patients and allow for a wider and deeper debate about the inclusion of a drug or treatment in the system. Through collective claims interest parties such as ANVISA and CONITEC, pharmaceutical companies and other associations, would be able to take part in the procedure or be heard at public hearings (as amicus curie, for instance).

Beyond collective litigation, the Brazilian legal system also provides for other mechanisms of solving repetitive litigation that could be applied to the health care cases analysed here. The *New Civil Procedure Code* enacted in 2015 had as its principal goal giving efficiency to lawsuits, particularly focusing on mass-litigation, repetitive claims and stability of the legal system[548]. One of the new instruments created with that purpose was the *Incidente de Resolução de Demandas Repetitivas (IRDR)*[549], an incidental joinder procedure which allows the selection of a model case to be used as paradigm for other repetitive claims requesting similar legal or fact. In so doing the procedure avoids conflicting judicial decisions and multiplication of individual claims with similar object – such as the ones offered by patients requesting the same medical device or drug. These pilot-case proceeding, largely inspired by the German *Musterverfahren* procedure, enables courts to aggregate claims and decide the dispute based on the "best representative of the controversy". Furthermore, it gives judges the power to identify repetitive claims and aggregate them *ex officio* - without the need of a party

[547] Ada Pellegrini GRINOVER, Kazuo WATANABE, Ligia Paula Pires Pinto SICA *and others*, *Avaliação da prestação jurisdicional coletiva e individual a partir da judicialização da saúde*, 2014)and Luís Roberto BARROSO, 'Da falta de efetividade à judicialização excessiva: direito à saúde, fornecimento gratuito de medicamentos e parâmetros para a atuação judicial' (2009) Disponível em:
[548] Antonio CABRAL, 'Standard-solution procedures and mass litigation' (2016) 6 IJPL 263
[549] Articles 976 to 987 of the Brazilian Civil Procedure Code (Law n. 13105/2015).

request. Parties are also able to request the joinder it via simple petition. If the incidental procedure is accepted, then all other lawsuits, individual and collective, discussing the same topic are suspended until the IRDR is resolved, and the decision is applied *erga omines* to all similar cases.

The average citizen, however, is unable to start a class action in the Brazilian system – although any litigant can request the joinder via IRDR. Class actions can only be proposed by a narrow list of legitimate petitioners[550], which includes the Prosecutor's Office and the Public Defender's Office and associations legally structured for at least one year, and whose institutional purposes include the defence of diffuse, collective, or homogeneous individual rights.

If the Brazilian legal system provides for different procedural instruments for resolution of repetitive claims, then why are there no more class actions and representative lawsuits (IRDR) filed in access to health care cases? According to a public defender from Rio de Janeiro answered:

> I think the fear of losing and ending up affecting everyone. It is difficult to get an injunction in these class actions. Because it easier to think that each case is one case, and that the criterion for this person is not applicable to another person. So, putting it in the collective is worrying. It is much easier to be successful in the individual lawsuit. Because when the judge grants in the collective it is as if (s)he changed the entire public policy. And in the individual case, (s)he is only ruling on each case, concretely[551].

The public defenders' quote illustrates not only the litigants' individual choice for the perceived best and most certain legal strategy but also the judges' perception that granting individual cases would not render a change of public policy (and therefore not be a breach of separation of power or judicial activism). This description feeds into the typology of activism which I describe in Chapter 4, whereby Brazilian judges exercise a type of attenuated activism

[550] Defined in article 5 of Law n. 7347/85 and article 82 of the Consumer Code (Law n. 8078/90).
[551] Interviewee 22 (2016) Interview with litigant in Rio de Janeiro (RJ) [09/12/2016]

through individual cases, and with use of legal mechanisms that do not seem to result in interference of the Executive's power.

Furthermore, in the case of joinder, once the IRDR incident is accepted by a jurisdiction, its analysis is sent to a higher judicial degree. For instance, if the repetitive claims are identified by a São Paulo first degree judge, then the appellate court of São Paulo will be responsible for deciding the incident. However, if the repetition is observed in several different states of the country, then the Superior Court of Justice is the one called to resolve the repetitive legal issue. Moreover, if a first-degree judge identifies a repetition, or grants the start of an IRDR requested by the parties, then the case is sent to the appellate court for decision. This means that the lower court judge "loses the power" of deciding that claim – and all others related to it. This perception of losing the power to decide the claim was mentioned by interviewees as a factor prevent some judges of requesting the joinder procedure. As one judge from São Paulo describes:

> It would be good to have the other side of the debate in the lawsuit [referring to the possibility of hearing the policy maker to the legal action] (...). This would be possible using the incident [IRDR]. But if I start an incident it goes to the appellate court… and I am not sure… there are things that happen there I cannot talk about [referring to corruption][552].

Therefore, the collectivisation of heath care claims in Brazil does not seem to be deterred by legal reasons, but because of litigants' (and attorneys) individual perception that such claims are less likely to be granted, lack of knowledge of such legal route, and judges' lack of willingness to trust the higher courts, and to lose power of the cases under their docket.

[552] Interviewee 14 (2016) Interview with first degree judge in (SP) [03/12/2016]

A similar facet of all the three explanatory factors suggested above is the individualism which I explore throughout this chapter, and that is further incentivised by the decisions of judges granting individual claims.

> They don't litigate collectively because they lose. Because when it comes to the *ação civil pública* [class actions], things get serious. It is much easier to pulverize the cases in individual lawsuits. Sometimes, the petitions are identical, everything is the same, only the patient's name changes. The doctor's prescriptions are the same. But, through individual claims, one case is sent to one judge, another to a second judge, another to a third judge… you spread the cases and increase the chance of winning. If they start a collective suit, then they have much less chance to win because it is much more serious. The class action will result in Executive incorporating a drug for all citizens to acquire. It is a change in the policy. This is serious, very serious, because is a complete interference of the Judiciary in the Executive, which is wrong. (…) In the individual lawsuit, the judge thinks (s)he is not interfering in the public policy. It is unconscious, but (s)he thinks: I am only taking care of this individual case here, without thinking that this one case will reflect on the public policy. So, it is a self-deception of the judge. I think it is much easier to decide in relation to just for one person than to strike a pen against the State, and to give it to everyone... it sets a strong precedent[553].

The choice for individual litigation is thus another expression judges and litigants manoeuvering the law to achieve a desire result – a legal *jeitinho*. By choosing not to applying the best legal and procedural solution to repetitive cases, judges mask the impact their pulverised decisions have in the public policy, as a whole. By litigating individually, litigants and the patient's associations who often assist them choose the easiest way to solve their own personal problems despite wider implications for the collective. Finally, by fostering individual litigation, pharmaceutical companies find a way to dodge the administrative proceedings and profit from judicial decision. And a justification, all these actors (from judges to litigants and pharmaceutical companies) use their perception of a corrupt government, and inefficient public policy to legitimate their individualistic choices.

7.4 Conclusion: an individual *jeitinho* for a collective problem

[553] Interview with public official from CONITEC, Ministry of Health care in Brasília on February 6th, 2017.

Concluding, in a country where citizens do not feel protected by the State; where there is a generalised feeling of distrust and discontent with public authorities, and where people are driven to find the easiest (even if only perceived to be so) way around their problems, the Judiciary becomes the only – or easier - access to public services. Cultural individualism becomes tangible in courts. The mass individual[554] litigation, reflected in the multiplication of lawsuits filed against the State, instead of collectively or in aggregated form, illustrate the triumph of the individual interest over the collective. Even though the types of health care legal actions started by litigants in Brazilian courts very often possess the procedural and material attributes that could justify the application of joint or aggregative techniques[555], this does not seem to be the preference amongst Brazilian litigants and their legal representatives[556]. And this is not incentivised by judges themselves. Instead, there is a market which incentivises the choice of individual litigation. This encompasses the self-driven interest of various actors, including medical doctors, patient's associations and the pharmaceutical industry who indirectly benefit from the massification of health care litigation.

Interestingly, this is not a phenomenon restricted to the Brazilian experience. The multiplication of health care litigation via individual legal action is also identified in Colombia. In the next chapter I offer a comparative analysis of health care litigation between Colombia and the UK.

[554] By mass individual litigation I do not refer to mass tort litigation, usually referred to by the American procedural system, as lawsuits seeking reparation for damages. Although these types of actions are also present in Brazilian Judiciary, by mass litigation here I refer to a broader phenomenon framed by Mauro Cappelletti in what he calls a *massification of law:* "Faced by such fascinating, yet dangerous, social phenomena of gigantic and universal dimensions, the law, as an instrument of social order, must undertake tasks unknown in previous times". (Mauro CAPPELLETTI, 'Vindicating the public interest through the courts: A comparativist's contribution' (1975) 25 Buff L Rev 643)

[555] On aggregating techniques for mass litigation: Daniel M BRINKS and Varun GAURI, 'The law's majestic equality? The distributive impact of judicializing social and economic rights' (2014) 12 Perspectives on Politics 375 and Roger H TRANGSRUD, 'Joinder alternatives in mass tort litigation' (1984) 70 Cornell L Rev 779

[556] GABBAY, ALVES DA SILVA, DE ARAUJO ASPERTI *and others*, 'Why the'Haves' Come Out Ahead in Brazil? Revisiting Speculations Concerning Repeat Players and One-Shooters in the Brazilian Litigation Setting'

CHAPTER 8 – COMPARING HEALTH CARE LITIGATION: HOW DO THE SOCIO-LEGAL FACTORS OBSERVED IN BRAZIL OPERATE IN THE CONTEXT OF COLOMBIA AND THE UNITED KINGDOM?

In this chapter I ask if the above-mentioned factors, both sociological and legal, are specific to the Brazilian experience or if they can be identified as relevant also in other countries. To conduct this comparative investigation I chose Colombia, a country which experiences a very similar phenomenon of mass-individual litigation for access to health care, and the United Kingdom, a country where access to health care litigation is rarer and dealt with in a very different way by British courts. By comparing Colombia and the United Kingdom we can observe the same phenomenon through the lenses of very different sociological contexts, and different legal systems which in turn have an important bearing in on how judges decide these claims – not only with reference to the outcome of the lawsuit, but also to the legal instruments used to justify it. For example, by comparing the case of Brazil with a "similar" country experience – Colombia – which experiences high levels of inequality and distrust in public institutions, and a very different one – United Kingdom – where society is much more equal, and public institutions enjoy higher trusting levels, we can observe how the same factors analysed throughout this thesis – i.e. trust, constitutionalisation of rights – can operate differently depending on the sociological context of a country.

Comparative legal analysis – in this case of socio-economic rights litigation - is a contentious field, subject to valid criticisms which point to the fact that the sociological and historical specificities of a society cannot be ignored for the sake of developing a transversal theory[557] - equally applied across countries irrespective of their socio-legal specificities. That being said, even though my goal here is not to develop an overarching theory about health care

[557] Michel ROSENFELD and András SAJÓ, *The Oxford handbook of comparative constitutional law* (Oxford University Press 2012)

litigation, the comparative study of other jurisdictions contributes to the development of medium range theory which identifies the main legal and sociological factors driving litigation for access to health care in a range of different jurisdictions.

For example, by comparing successful lawsuits requesting access to drugs, treatments or medical devices in Colombia, Brazil and the United Kingdom, it is possible to observe different relationships courts establish with public bodies involved in the administration of health care. For instance, in the UK, where courts are much more deferent to the expertise and discretion of the health authorities, judges focus their analysis during judicial review proceedings on administrative law, such as the Wednesbury test for judging the lawfulness of the health authorities' (NHS trusts or Secretary of State for Health) decisions. In Brazil and Colombia, however, [most] judges consider that the mere existence of a constitutional provision for a right to health or/and right to life is enough to grant individual citizens the right to access any drug, treatment or medical device needed, despite decisions of the administration in *contrario sensu* - very often without even analysing the administrative decision at all.

Nevertheless, answering the question as to why courts in one jurisdiction are more prone to deciding judicial review cases against the administration in the case of health care is one that cannot be understood solely through case law analysis. As the central argument to my thesis points to, the sociological factors underlying judicial decision-making are essential to really understand the complex nature of increases in successful litigation for access to health care (and social-economic rights litigation more widely). As the literature shows, there are very few empirical studies which fill this socio-legal gap, leaving a space also for future research to be conducted.

Given the limitations of time and thus scope of this comparative analysis, I will not be able to analyse each of the sociological and legal factors explored in the Brazilian case. Instead, I will focus in this chapter on two factors identified as key to the development of the mass-

litigation phenomenon in Brazil: constitutionalisation of rights and use of human rights in judicial decision making - as a central legal factor, and trust – as a central sociological factor.

As said above, the analysis which I undertake in this chapter is not an exhaustive comparison of all the factors analysed in the Brazilian case to Colombia or the UK. To begin with, because any comparative legal analysis is limited by the impossibility of perfectly comparing health care litigation, given the varying context of different societies. Furthermore, my research was designed as an in-depth case study of the underlying socio-legal factors of health care litigation in Brazil, and my main focus on building a deeper socio-legal understanding of a complex phenomenon in the Brazilian context, informed by in-depth qualitative empirical research. Therefore, only a similar in-depth research about Colombia and the UK would enable to include all factors identified in the Brazilian case, and thus would allow for a more extensive comparison. Nonetheless, this chapter is important, first, to stress the significance of understanding socio-legal phenomena such as judicial activism in the context of health care litigation from a contextualised, in-depth perspective. Secondly, to ask a first fundamental question in any comparison, i.e., to examine if the socio-legal factors observed in the Brazilian case are actually part of a wider phenomenon of an increase in successful health care litigation, which can be also observed in other countries such as Colombia or the UK, or whether the socio-legal factors that I identified in this thesis are only relevant in the Brazilian context.

In order to start this comparative exploration of judicial activism in the context of health care litigation in Colombia and the UK, I analysed twelve key judicial decisions (indicated in the literature) from higher courts – i.e., Colombia's Supreme Court, and the UK's Court of Appeal and Supreme Court, in order to understand how courts, position themselves vis a vis the Executive in access to health care cases and what legal reasoning they develop. Unfortunately, in both countries – as it is in Brazil – lower courts' decisions are hard to access

and given much less publicity. This is partly due to the high number of judges and cases which are filed before individual judges in Brazil and Colombia, but it also indicates a key point highlighted in the research which is the lack of attention given by academia to the activism of first degree and lower court judges. Therefore, I do not analyse lower court decisions in this chapter but highlight the importance of further understanding judicial activism from the perspective of the individual and lower court judges.

This chapter will therefore help to understand how portable the findings in relation to Brazil are to other countries, particularly ones with similar sociological and legal contexts such as Colombia. The chapter will also raise questions about how the factors identified for explaining why there is a significant increase in successful health care claims in Brazil, operate in jurisdictions which do not see high levels of successful health care claims, such as the UK. By undertaking a comparative analysis of these two jurisdictions with the in-depth case study about Brazil, I can shed light on the question whether and to what extent the Brazilian case is quite unique or shares similarities with other jurisdictions, and I can also help shed light on avenues for further research about other jurisdiction, and how to develop tools to limit the litigation pandemic observed in Brazil and in Colombia.

8.1. The case of access to health care litigation in Colombia

> After more than 200 years, it is clear that the separation of public powers is not enough warranty against abuses. Nor is the detailed enumeration of the faculties of those who hold authority. What is missing is to attribute power to the citizens and create mechanisms for them to exercise it directly, peacefully …: transfer power to the regular citizen so that when he or she has been treated arbitrarily, that person has an alternative to aggression, incendiary protest or submissive and alienating resignation … That medical care could not be denied to a poor person whose life is in danger, and a judge could order a hospital to provide immediate assistance to him … In short, let arbitrariness cease.[558]

[558] President César Gaviria, National Constituent Assembly, February 5, 1991 (Aquiles IGNACIO ARRIETA-GOMEZ, 'Realizing the fundamental right to health through litigation: the Colombian case' (2018) 20 health and human rights 133)

The right to health care is provided for in article 12 of the International Covenant on Economic, Social and Cultural Rights[559]. According to the provision, every signatory State Party must recognise the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health'[560]. Whilst some jurisdictions[561], such as Brazil, South Africa, Thailand and Senegal – to name a few – expressly foresee the justiciability of the right to health care rights in their constitutions, other countries such as Colombia, India and the United Kingdom, do not do so. That has not deterred the sharp rise of successful health care litigation in Colombia and India, however. In both these countries the Constitutional Courts developed an interpretative understanding which allows for the justiciability of health care as deriving from the constitutional rights to life and dignity, enshrined in their constitutions[562].

Moreover, the lack of express provision of the right to health care in the Colombian Constitution did not prevent it from developing a health care litigation phenomenon consisting of an increase in successful claims for access to health care. On the contrary. The country was, alongside Costa Rica, one of the first in Latin America to witness a sharp increase of individual lawsuits filed against the State claiming access to drugs, treatments and medical devices not available in the national health system.

The phenomenon of mass-litigation for access to health care in Colombia has its start in 1991, when a liberal constitutional reform culminated in the enactment of a new Constitution – which came to be known as the Constitution of Human Rights, and the institution of a more

[559] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR)

[560] Article 12 ICESCR

[561] According to a report of the Office the United Nations High Comm'n for Human Rights (OHCHR) from 2008, at the time at least 115 constitutions around the world expressly recognized health care as a constitutional right (Office of the United Nations High Commissioner for Human RIGHTS and World Health ORGANIZATION, *The Right to Health. Fact sheet no. 31* (United Nations Geneva 2008)).

[562] Alicia Ely YAMIN and Siri GLOPPEN, *Litigating health rights: can courts bring more justice to health?*, vol 3 (Harvard University Press 2011)

modern, and powerful, Constitutional Court[563]. The new Colombian Constitution expanded the constitutional jurisdiction to all judges in the country and introduced several mechanisms which facilitated access of regular citizens to the Judiciary, amongst which the *acción de tutela (*provided for in article 86 of the Colombian Constitution[564]). The writ, which is comparable to the *amparo* recourses in other Latin American countries[565], gave every individual in Colombia legal protection against the actions and omissions of public and private authorities[566], enabling interim orders to be granted in cases of imminent and irreparable damage to the claimant's fundamental rights.

The *tutela* can be processed by any judge in the country and is offered a preferential and summary proceeding (i.e., the Colombian Constitution commands that decisions of *acciones de tutela* be granted within ten days of its offering). This allows for the immediate protection of an individual or a collective's (class) fundamental rights. Through the *tutelas* the Colombian Constitution of 1991 introduced a powerful legal instrument for the protection of the citizens against impending damages to fundamental rights. Similarly to what is observed in Brazil from the enactment of the 1988 Constitution, legal instruments such as the *tutelas* made it easier for citizens to litigate their fundamental rights, consequently increasing the power of judges from all levels. Very early on, both countries saw a rapid raise in the use of constitutional

[563] Alicia Ely YAMIN and Oscar PARRA-VERA, 'Judicial protection of the right to health in Colombia: From social demands to individual claims to public debates' (2010) 33 Hastings Int'l & Comp L Rev 431

[564] Article 86, Constitution 1991, Colombia: 'Every individual may claim legal protection before the judge, at any time or place, through a preferential and summary proceeding, for himself/herself or by whoever acts in his/her name, the immediate protection of his/her fundamental constitutional rights when the individual fears the latter may be jeopardized or threatened by the action or omission of any public authority. (…) The order, which will have to be implemented immediately, may be challenged before the competent judge.'

[565] The writ of *amparo* is a constitutional action originated in Mexico, and then imported by other Spanish jurisdictions, such as Argentina, Chile and Haiti. Brazil has a similar mechanism known as *mandado de segurança*.

[566] In 2019 the Constitutional Court decided that *tutelas* could be used against international arbitration awards, which violated fundamental rights (Sentencia T-354/19, Constitutional Court, Colombia (2019)).

litigation to get access to health care[567].

Moreover, analogously to the small claims court's procedures used by Brazilians to litigate access to health care (explained in Chapter 1), the Colombian *tutelas* are also free from any cost – including in loosing cases - and can be started without the need for a lawyer. As a consequence, soon the *tutelas* flooded Colombian courts at every level. The *tutelas* became the most popular legal instrument in Colombia and were responsible for a sharp increase in the volume of caseload analysed by Colombian Courts[568]. This becomes apparent also from an article published in the newspaper El Tiempo[569], which referred to a Supreme Court Justice, Dídimo Páez, who developed ulcers due to the avalanche of *tutelas* he had to decide every day.

In 2019, there were 207.363 *tutelas* filed in Colombian courts for access to health care. That represents roughly one case per 240 inhabitants, while Brazil has recorded roughly one health care claim per 95 inhabitants in 2019[570]. Both countries, thus, have high rates of litigation with equally high rates of success – in Colombia, the success rate of *tutelas de salud* are around 80%[571], which is similar to the success rates observed in some states of Brazil[572] (with the caveats made in the introductory chapter about the difficulty of measuring success rates of all health care litigation in Brazil due to a lack of a standardised judicial system for awarding remedies). Furthermore, in both countries health care litigation is a big part of the number of lawsuits filed for access to socio-economic rights. In Colombia, health care claims

[567] NUNES, 'Ideational origins of progressive judicial activism: The Colombian Constitutional Court and the right to health'

[568] Delaney Patrick DELANEY, 'Legislating for equality in Colombia: Constitutional jurisprudence, Tutelas, and social reform' (2008) 1 The Equal Rights Review 50

[569] Magistrados, con úlcera por tutela, *El Tiempo*, Colombia, August 27th, 1997. Available at https://www.eltiempo.com/archivo/documento/MAM-605037.

[570] CJ SCHULZE, 'Números de 2019 da judicialização da saúde no Brasil' (2019) Empório do Direito

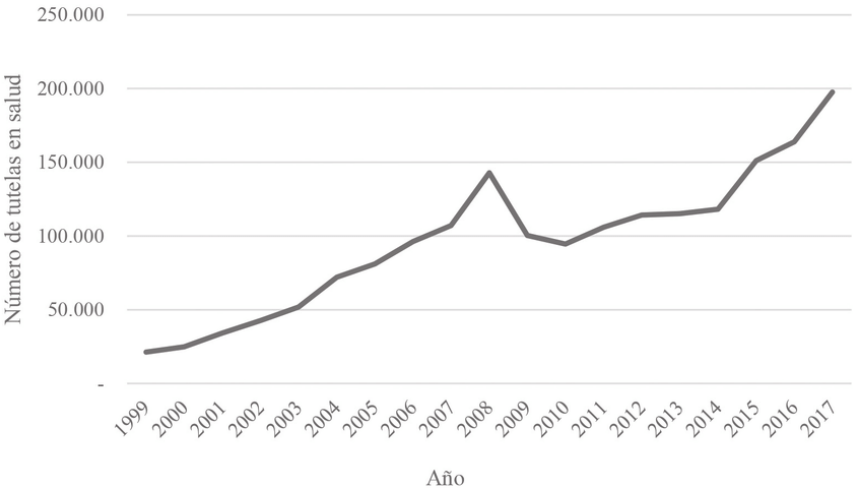
[571] Alicia Ely YAMIN and Oscar PARRA-VERA, 'How do courts set health policy? The case of the Colombian Constitutional Court' (2009) 6 PLoS Med e1000032

[572] For example, in São Paulo courts, the success rates of health care claims average 85% according to Daniel Wei L. WANG, 'Right to Health Litigation in Brazil: The Problem and the Institutional Responses: Figure 1' (2015) Human Rights Law Review ngv025.

accounted for 34% of all *tutelas* filed in 2018. From those, 98,4% of *tutelas* in Colombia requested treatment, medical procedures and surgeries, while 73% requested access to medical devices and 72% access to drugs – it is important to stress that the total exceeds 100% as most claims request more than one type of health care service[573].

Figure 8 illustrates how the number of *tutelas* have continued to grow – with the exception of a slight fall in numbers in 2008, after the Constitutional Court's decision T-760/2008, which I discuss further in the next section.

Figure 8: Number of Tutelas in Colombia from 1999-2017



[574]

The soaring numbers of successful legal claims in Brazil and Colombia incentivised the development of a health care litigation market, which I analyse next.

[573] The statistics were developed by the Public Defender's Office and are available at https://www.defensoria.gov.co/es/nube/enlosmedios/5911/Cada-35-minutos-se-presenta-una-tutela-por-la-salud.htm, access on 28th of December, 2020.

[574] Gabriel OTÁLVARO CASTRO, Daniel PATIÑO-LUGO, Diana MAZO *and others*, 'La acción de tutela por el derecho a la salud en Medellín. Tendencia y aproximación general a las tutelas en salud cogestionadas por la ciudadanía en la Personería de Medellín entre 2008 y 2018', (2019)

8.1.1 The commodification of health care litigation in Colombia

The economic incentives described so far in this Chapter for Colombia – low costs for starting individual litigation – i.e., strong legal aid, no need for lawyers and zero court fees including in cases of loss - and high success rates are very similar to those encountered in Brazil. Is not surprising, then, that the *commodification* of health care litigation which is observed in Brazil also takes places in Colombia.

As explained in Chapter 6, interviewed litigants in Brazil displayed a very utilitarian and individualist relationship towards the health care system and litigation. When asked if litigants trusted the courts, their answer was that they trusted that they would get access to the drugs needed via litigation. Their description of the process was not one which referred to litigation for access to public services as an act of citizenship or even pointed the importance of claiming human rights, but a calculated decision of how easy and costly it would be to get access to the treatment or drug via courts. This relationship litigants described with both courts and the health care system was then analysed in conjunction with the sociological context of Brazil, and the presence of an individualist society who relates to public services in a consumerist manner. Although it is difficult to establish a direct comparison with Colombia without interviewing litigants, the high numbers of individual *tutelas* filed in Colombian courts could indicate the presence of a similar sociological factor. Furthermore, the literature points to a similar development of an individualistic logic in the way the health care system in Colombia was designed, whereby Colombians understand the right to health care as an individual right rather than a collective one[575]. This analysis makes sense under a Colombian societal logic that connects wellbeing with individual purchase power and a culture centred

[575] Mario HERNÁNDEZ, 'Reforma sanitaria, equidad y derecho a la salud en Colombia' (2002) 18 Cadernos de saúde pública 991

around consumerism[576].

In a culture that understands health care as an individual right, which would thus grant the individual with access to whatever drug or treatment required, litigation and health care become a commodity traded in a wider market of judicial services/legal services/health care services. This dynamic, which is explained in Chapter 7 in relation to Brazil, can also be observed in Colombia, where we can find a market in the supply of legal remedies offering specialised consultancy in health care *tutelas* in social media. The page of a consultancy 'Tutela Salud Colombia' on Facebook, for example, claims that "we get the judge to resolve your case in an approximate time of 2 to 3 hours depending on the complexity" (Figure 9 below). Another page, "tutelatusalud.com", offers "*acciones de tutela* in health care in a very easy way, in a short period of time"[577].

[576] María Isabel Pascual DEL RIQUELME MARTÍNEZ, Mónica Eugenia Peñalosa OTERO and Diana María López CÉLIS, 'El consumo socialmente responsable en el mercado colombiano' (2015) 11 Cuadernos Latinoamericanos de Administración 61

[577] https://www.facebook.com/TutelaTuSalud/, accessed on 6th of January 2021.

Figure 9: Facebook Page 'Tutelas Salud Colombia'

[578]

(The post reads: Health *tutelas* Colombia: we get the judge to decide your case in an approximately 2 to 3 hours dependent on the complexity of your health condition, reminding that time is vital, Colombia must know the law)

The development of a market in health care litigation is both a consequence and a cause of the mass individual litigation observed both in Brazil and Colombia. The involvement of third parties, such as patient's associations in the case of Brazil, health care litigation consultancies in Colombia, and pharmaceutical companies in both countries[579] are important factors influencing the phenomenon. Pharmaceutical companies play a critical albeit discrete role in fostering health care litigation - especially in cases involving high-cost drugs. Seldom these companies participate as parties in litigation, especially when these litigations are presented by individuals and not collectively. Therefore, the way in which pharmaceutical companies (both transnational and national) have found to influence health care litigation, and in consequence have the health care system acquire their drugs via judicial orders, is to either

[578] https://www.facebook.com/Tutelas-Salud-Colombia-124672954861886/, accessed on 6th of January 2021.

[579] On a comparative analysis about the role of pharmaceuticals and other transnational actors in the health care litigation phenomenon see Mindy Jane ROSEMAN and Siri GLOPPEN, 'Litigating the right to health: Are transnational actors backseat driving?' (2011) Litigating health rights: Can courts bring more justice to health 249

offer free legal advice to patients[580], or to finance the NGOs and patient association who give free legal advice to patients. This dynamic was confirmed throughout many interviews with representatives of the pharmaceutical companies[581], patients associations[582] and litigants[583] in Brazil. In the case of Colombia, there are accounts of indirect financing of health care litigation by pharmaceutical companies in the literature[584], but a deeper understanding would require further research.

Therefore, the mechanisms of health care litigation in Colombia seem to have also led to the development of a market in litigation, in a similar manner as the one identified in Brazil. Cheap litigation, high rates of success and a powerful industry-force incentivising it, have not only led to extremely high numbers of successful health care claims, but also fuelled the development of informal markets[585] of lawsuits against the government.

The economic drivers formed by the three factors above mentioned (cheap litigation, high success rates and interests of the pharmaceutical industry) do not tell the whole story. As the core of my research indicates, the context of a widespread distrust in Brazilian institutions was an essential factor influencing a litigant's decision to start legal claims, and utilitarian trust in judges' decisions and a judge's disposition to grant health care lawsuits. Next, I analyse how the legal and sociological factors identified in the Brazilian case can be observed in Colombia, starting by explaining how the health care system in Colombia is structured.

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[580] Interviewee 9 (2016) Interview with litigant in Guarulhos (SP) [21/11/2016]

[581] Interviewee 41 (2017) Interview with representative of a pharmaceutical company in São Paulo (SP) [26/01/2017]

[582] Interviewee 35 (2017) Interview with representative of a patients' association in São Paulo (SP) [17/01/2017]

[583] Interviewee 12 (2016) Interview with litigant in São Paulo (SP) [24/11/2016]

[584] On Colombia, see Everaldo LAMPREA, 'Derechos en la práctica: Jueces, litigantes, y operadores de políticas de salud en Colombia (1991–2014)' (2015) Ediciones Uniandes

[585] As explored in chapter 8, this informal market – as I refer to it - is a by-product of high rates of successful health care litigation and the economic incentives it creates. This informal market would encompass cases of (i) third-party financing by pharmaceutical companies and patients' associations, (ii) fraudulent schemes of lawyers and medical doctors using courts as a way to make cities and states purchase drugs or devices (i.e., orthopaedic prothesis), and (iii) illegal reselling of medical products and drugs acquired through litigation via social-media (i.e., Facebook) and other market websites (i.e., Mercado Livre and eBay).

8.1.2. Background: Colombia's health care system

The modern Colombian health care system is regulated by Law 100, enacted in 1993[586]. The Law was the result of a comprehensive reform of the health care system in Colombia which had as its core objective to make health care a universal service, according to which all citizens could access an 'integral social security system'. The health care reform in Colombia is, however, part of a much wider Constitutional movement undertaken during the late 80s and early 90s all throughout Latin America, which expanded significantly the constitutional provisions of socio-economic rights (also called the rights revolution[587]).

The Law 100 determines that the health system should be based on the principles of efficiency, universality, solidarity, and participation (article 2[588]). It also introduced a new, combined health system - General Social Security Health System (*Sistema de Seguridad Social en Salud*) - which is governed by the State but delivered by several different health care providers (Instituciones Prestadoras de Salud, IPS). The system is financed by two different plans: one contributory and one subsidised. The first, contributory regime, covers workers, pensioners, and independent workers who contribute according to their salaries. The second, subsidised model, covers all of those who are unable to participate in the contributory model[589].

This means that although also a universal health care system (such as the ones in Brazil and the UK), the Colombian health care system is structured on a different basis. Whilst in

[586] Law 100, 1999, Colombia: Book II of the General System of Social Security in Health. Bogotá, Colombia: 1993 (http://www.alcaldiabogota.gov.co/sisjur/normas/Norma1.jsp?i=5248, accessed 21 February 2017)

[587] Bruce M WILSON, 'Institutional reform and rights revolutions in Latin America: The cases of Costa Rica and Colombia' (2009) 1 Journal of Politics in Latin America 59

[589] Available at Paho, https://www.paho.org/salud-en-las-americas-2017/?p=2342, access on December 20th, 2020.

Brazil the SUS, and in the UK the NHS, are unified systems which cover all citizens equally, in Colombia citizens access health care from one of two types of insurance providers depending on their social-economic statuses: (i) a free government-subsidised system offered to poor and homeless Colombians, and (ii) a private system offered by different *Entidades Promotoras de Salud* (EPS) – private entities which are delegated a public service. This means that in Colombia, health care claims (*tutelas*) are usually filed against the private entities with which the litigant is affiliated, and not the public health authority (such as in Brazil and the UK).

The structure of the Colombian health care system – of separated providers in accordance with income – could also make the inequalities in the health care system to be more tangible to Colombians[590] in comparison to universal system, such as Brazil and the UK. Colombia is classified by the World Bank as an upper middle-income country with high levels of inequality[591], which means that it is also a country of "haves" and "have nots"[592] – such as Brazil. Within a context of poverty, the health care system also suffers. There is a widespread perception amongst Colombians, that the health care system has been deteriorating, and that it does not offer the service quality promised by the Constitution. For example, a global comparative research conducted by Ipsos in 2018 shows that only 25% of Colombians rate the quality of their health care as "good" and 44% rated it as "poor"[593]. The same research also indicates that 78% of Colombians believe that "people in their country cannot afford good health care"[594] and that only 17% of Colombians agreed that "the health care system in my

[590] Johnattan GARCÍA, 'Closing the gap between formal and material health care coverage in Colombia' (2016) 18 health and human rights 49

[591] Data available at https://databank.worldbank.org/views/reports/reportwidget.aspx?Report_Name=CountryProfile&Id=b450fd57&tbar=y&dd=y&inf=n&zm=n&country=COL, accessed on 3rd of January, 2021.

[592] Pablo ASTORGA JUNQUERA, 'The haves and the have nots in Latin America in the 20th century' (2016) Revista de Economía Mundial 2016;(43): 47-68

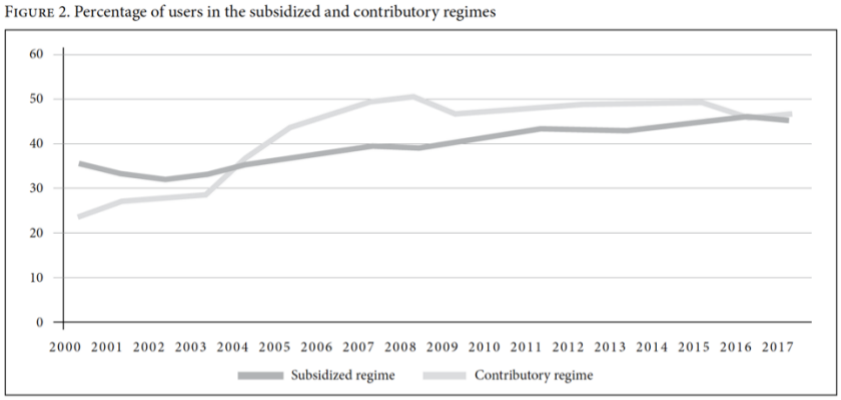
[593] MORI IPSOS, *Global Views on Healthcare* (Global Advisor, 2018) 30

[594] Ibid

country provides the same standard of care to everyone"[595].

The perceptions seem to mirror, to a certain extent, the reality of health care in Brazil. Moreover, as it can be inferred by the Figure 10 below, the percentage of Colombians covered by the subsidiary system – the lower level of health care coverage in the country – has been increasing instead of decreasing. Fewer Colombians today have access to good quality health care than in the early 2000s.

Figure 10: Percentage of Colombians under subsidised and contributory health care regimes



Source: Así Vamos en Salud. Available at http://www.asivamosensalud.org/indicadores/aseguramiento/aseguramiento-georeferenciado. [596]

Comparatively, the Brazilian health care system, albeit structured over a universally public, free system, is also largely supplemented by private insurance companies. This means that, de facto, the Colombian and Brazilian health systems have important similarities – i.e., rich citizens of both countries tend to supplement their health care by paying extra for private insurance companies, which in turn gives them access to private hospitals and clinics. In fact,

[595] Ibid

[596] IGNACIO ARRIETA-GOMEZ, 'Realizing the fundamental right to health through litigation: the Colombian case', 142

two judges interviewed[597] have pointed out the fact that they – and most judges they know - have never used the public system (SUS), which contributes to their perception that the public system is of bad quality. Therefore, although there are important differences in terms of the design of health care in Brazil and Colombia, in reality the way they are experienced by judges, and more widely by society, can be quite similar: whilst a rich minority makes use of a better system, a larger fragment of the population is offered a "bad quality service"[598]. This fuels the perception that the 'basic plan' is not good.

In 2000, for example, pressured by the numerous decisions of health care *tutelas* and several decisions of the Colombian Constitutional court, the government required that EPS companies expand the list of medicines offered in their benefits plan. These medicines could then be reimbursed by the local state authorities[599].

As will be shown in the next section, several of the reforms undertaken by the Colombia health care system followed from decisions of the Judiciary – and in particular the Constitutional Court.

8.1.3. Understanding the legal in the Colombian socio-legal: what is the legal treatment given by Colombian courts to lawsuits requesting access to health care?

The 1991 Colombian Constitution provides for the right to health care in article 49[600],

[597] Interviewee 38 (2017) Interview with first-degree federal judge from São Paulo (SP) [22/01/2017] and Interviewee 2 (2016) Interview with a Supreme Court judge in Brasília (DF) [16/11/2016].

[598] In order to approximate the comparison with Brazil, I refer to both subsidized and compulsory contributive models as 'public service'. As private service I refer to the commercial insurance companies, which represent 5% of the health care coverage in Colombia according to Ramiro GUERRERO, Sergio I PRADA, Ana Melissa PÉREZ *and others*, 'Universal health coverage assessment Colombia' (2015) Global Network for Health Equity .

[599] IGNACIO ARRIETA-GOMEZ, 'Realizing the fundamental right to health through litigation: the Colombian case'

[600] Article 49, Constitution, Colombia: 'Public health and environmental protection are public services for which the State is responsible. All individuals are guaranteed access to services that promote, protect, and rehabilitate public health. It is the responsibility of the State to organize, direct, and regulate the delivery of health services and environmental protection to the population in accordance with the principles of efficiency, universality, and solidarity'.

which states that health care is a public service for which the State is responsible, and all individuals have the right to universal health care. However, differently from the Brazilian Constitution, the Colombian Constitution did not expressly list health care as a fundamental right. This meant that Colombians could not use the *tutelas* as legal instruments to claim access to health care.

Moreover, *tutelas* are a constitutional instrument designed to protect citizens against violations of *fundamental rights* – i.e., those listed in the Title II of the Colombian Constitution (Articles 11 to 41) [which excludes social, economic and cultural Rights (Articles 42 to 77)].

However, since very early on the Colombian courts, including the Constitutional Court, have built an interpretation which allowed for *tutelas* to be filed in cases discussing the breach of a right to health care. According to the literature, this meant taking the right to health care from the realm of aspirational guarantees to justiciable constitutional rights, which could be then directly enforced in courts via tutelas[601].

In two paradigmatic cases decided in 1992 – Sentencia T-451/92 and Sentencia T-571/92, the Colombian Constitutional Court ruled that the list or rights foreseen in Article 85[602] of the Constitution or the chapter entitled 'Fundamental Rights'[603], was not *numerus clausus.* In other words, according to the Constitutional Court, the 23 justiciable rights listed in article 85 were mere examples, which could be amplified by application of the doctrine of connectivity[604]. Constitutional rights should thus be analysed on a case-by-case basis, as parts of a connected web of fundamental rights[605]. And thus, the right to health could be considered

[601] Katharine G YOUNG and Julieta LEMAITRE, 'The comparative fortunes of the right to health: Two tales of justiciability in Colombia and South Africa' (2013) 26 Harv Hum Rts J 179

[602] Article 85 provides for: "The rights mentioned in Articles 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 23, 24, 26, 27, 28, 29, 30, 31, 33, 34, 37 and 40 are applicable immediately" (Article 85, Constitution 1991, Colombia).

[603] Sentencia T-534/92, Constitutional Court, Colombia (1992)

[604] David LANDAU, 'The reality of social rights enforcement' (2012) 53 Harv Int'l LJ 189

[605] Sentencia T-451/92, Colombian Constitutional Court, 10 July 1992.

a fundamental right (subject to protection of the *tutelas)* by virtue of its connection to the right to life and dignity of the human-being[606]. According to the Constitutional Court:

> Health is one of those rights that, due to its inherent nature in the existence of every human being, is protected in our legal system, especially for the sake of real and effective equality, in people who, due to their economic, physical or mental condition, are in circumstances of manifest weakness. This right also seeks, and in a primordial way, the assurance of the fundamental right by nature: life, for which its welfare nature imposes a priority and preferential treatment by the government and the legislator, for the sake of its effective protection[607].

The use of this dynamic constitutional interpretation[608] – also understood as extensive, material or evolutionary approach[609] - allowed for the ample use of *tutelas* by individuals claiming access to drugs, treatments and medical devices not offered by the different health providers in Colombia.

The activism of the Colombian Constitutional Court did not stop at interpreting health care as a fundamental right, however. The *tutelas* soon became a powerful tool for legislative and regulatory reform in response to decisions of the Colombian Constitutional Court. Following the avalanche of *tutelas* claiming access to health care filed in Colombian courts since the 90's, in 2018 the Constitutional Court joined 22 cases brought by 20 individuals and two insurance companies and set out a paradigmatic decision which significantly reformed the Colombian health system[610].

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[606] Sentencia T-571/92, Colombian Constitutional Court, 26 October 1992

[607] Sentencia T-571/92, Colombian Constitutional Court, 26 October 1992

[608] On dynamic constitutional interpretation see Richard H FALLON JR, *The Dynamic Constitution: An Introduction to American Constitutional Law and Practice* (Cambridge University Press 2013) and Andrei MARMOR, 'Meaning and belief in constitutional interpretation' (2013) 82 Fordham L Rev 577

[609] Javier Tomayo JARAMILLO, 'The Colombian Constitution Court, A Sovereign Without Control' The Robbins Collection, Berkley Law

[610] Sentencia T-760/2008, Constitutional Court, Colombia (2008).

In the paradigmatic Sentencia T-760/08, the Constitutional Court asserted the right to health as a fundamental, right, and declared the health care system in Colombia to be in a state of unconstitutional affairs[611]. It then called for more transparency in system, particularly in how the benefits should be distributed in each of different coverage models, as well regular audits which could inform users about the performance of different providers and insurance entities, including the numbers of *tutelas* brought against them.

However, albeit establishing structural changes to the health care system and determining a number of conditions for a *tutela* to be granted[612], the Sentencia T-760/08 did not put an end to the *tutelas* claiming access to health care in the country. Today, Colombians continue to file *tutelas* in courts around the country to access drugs, treatments and medical devices, and continue to be successful under a legal reasoning of human rights. The reasons for such occurrence do not find explanation in the literature and could be further unrevealed through in-depth research.

8.1.4. Legal reasoning of *tutela* decisions in Colombia: human rights over deference

When analysing the legal behind the socio-legal in access to health care litigation on Brazil I demonstrated how the sociological factors brought up by judges during their interviews – such as trust and empathy – could not be identified in the published legal decisions. Instead, the decisions of the judges I interviewed mainly relied upon constitutional reasoning to justify

[611] IGNACIO ARRIETA-GOMEZ, 'Realizing the fundamental right to health through litigation: the Colombian case'

[612] "health care falling outside the POS can be immediately enforced through tutelas when the following conditions are met: (i) the lack of the medical service threatens the patient's right to minimum level of subsistence (mínimo vital); (ii) the service cannot be substituted by one contained within the POS; (iii) the patient cannot afford to pay the price of the required treatment or medication and cannot obtain such treatment or medication through any other health-care regime, such as insurance plans provided by employers or prepaid complementary plans; and (iv) the service has been ordered by a physician familiar with the patient's case." (Alicia Ely YAMIN, Oscar PARRA-VERA and Camila GIANELLA, 'Judicial protection of the right to health: an elusive promise' (2011) Litigating health rights: Can courts bring more justice to health 103)

grating access to health care. By analysing six key decisions of the Constitutional Court, we can identify the same happening in Colombia.

For example, in the Sentencia SU074/20 which discussed the right of five women facing infertility to access assisted reproduction treatments (*in vitro fertilisation*), the Constitutional Court understood that denying the access to treatment would not only breach the right to health care but increase the gap between the right to health enjoyed by wealthier and poorer citizens. This type of constitutional reasoning, which trumps cost allocation decisions made by health authorities based on human rights and social justice reasons, indicates the activism present in the Colombian court. According to the court in the Sentencia SU074/20:

> (i) In relation to human dignity, (…) the exclusion of highly complex assisted reproduction treatments from the General System of Social Security in Health imposes a limitation on the life project of people with infertility. (ii) Regarding the right to equality, the high cost of highly complex assisted human reproduction treatments (in vitro fertilisation) disproportionately affects people who lack sufficient economic capacity to defray their costs. Thus, even in particularly difficult circumstances for people and couples affected by infertility, many individuals face an insurmountable barrier to access the in vitro fertilization procedure, in contrast to those who have the ability to pay for the treatment at their own expense. (…) Hence, the State must intervene to avoid the disproportionate consequences that would be generated if only families with greater economic resources could have biological children as a result of specialised medical intervention or scientific assistance.[613]

Similarly to the Brazilian case, the outcome of successful *tutelas* in Colombia is a court provision that orders the health provider to perform a treatment or offer a drug to the claimant. In the case above, the health providers were ordered to conduct the *in vitro* treatment in the five litigants. As I discuss in section 8.2 below, in the UK even in successful lawsuits requesting access to health care in British courts, the judicial decisions' outcome is not to order the health provider – in this case the NHS or Primary Care Trusts – to perform a health treatment or offer a drug to the litigant, but review the the process of decision-making involved in health care

[613] Sentencia SU074/20, La Sala Plena, Colombian Constitutional Court, 18 July 2017.

allocation decisions by the administrative body, and various remedies, such as a quashing decision or a declaration of unlawfulness involve to remit the decision back to the original decision-maker i.e. the Secretary of State for Health and Social Care, or the NHS Trust or until 2013 Primary Care Trust. This stems from a wider discussion on the scope of judicial review in Brazil and Colombia – albeit part of literature understands that in the same manner as the UK, the Judiciary should limit its analysis to the legality of the administrative decision – when referring to matters of constitutional law, courts in Brazil and Colombia often revise the merits of the decision under the argument that it breaches a constitutional provision – i.e. the courts will go beyond analysing the legality of the administrative act and review the discretionary decision of resource allocation, therefore directly grant an individual or group the requested drug, treatment or device despite. The problem is that this "constitutional provision" is taken as a wide umbrella and often ignores the administrative discretion afforded to the public body making a decision about the availability of health care, including analysis of the safety and cost-efficiency of the drug, treatment of health device.

For example, in the abovementioned Sentencia T-760/08 which restructured the health care system in Colombia, the court declared that:

> The deference that the constitutional judge owes to the democratic debate and to the statutory laws as parameter to enforce the obligations of a progressive nature of a fundamental right, does not justify that said judge ignores his duty to guarantee the effective enjoyment of a right in the concrete case (…) agreeing with decisions which usually fall into the gaps *left by administrative norms or by the inefficiencies and bad practices of the authorities*[614].

The passage of the Constitutional Court's decision above is clear as to how the court understands the hierarchy between the statutory law, administrative decisions and the constitutional provisions. Similarly, in a case where the litigant required homecare for

[614] Sentencia T-760/2008, Constitutional Court, Colombia (2008).

osteoporosis and mobility treatments, including the installation of a hospital bed, the Constitutional Court understood that denying access to the litigant's medical requirements with reference to arguments of budgetary restriction infringed the claimant's right to health and human dignity.

> The economic implications of guaranteeing the right to health were analysed by the [Constitutional] Court in the aforementioned judgment C-313 of 2014, particularly when it analysed the principle of sustainability (…) and the exclusion criteria of the services and technologies of the health system. (…) For reasons of complexity and length, it is not necessary to go into detail on the arguments presented, however, it is important to mention that this Court admitted such exclusions and stressed that the financial balance is intended to guarantee the viability of the health system and, therefore, its permanence over time. 3.3.11. However, this conclusion - as elucidated in the judgment - *cannot lead to the misunderstanding of estimating that the recognition of the principle of economic sustainability is a cost-effective freedom to issue norms and make decisions that harm the rights of users and ignore the jurisprudence Constitution on effective and comprehensive access to health services*. In any case, the Court declared the enforceability of the principle of financial sustainability under the understanding that it cannot understand the refusal to provide efficient and timely all health services due to any user.[615]

Moreover, the Colombian Judiciary's interpretation of the right to health care foreseen in the Constitution trumps most restrictions imposed by the administrative authority, even if such restrictions were imposed by the administrative authority in accordance with the statutory law. The same happens in Brazil. Human rights provisions enshrined in the Brazilian and Colombian Constitution serve as a trump card to disregard the administration's decision to allocate a health budget and the statutory law[616].

As analysed in Chapter 3, when asked why courts were not deferential to the expert decisions of health care authorities, many interviewed judges replied that they could not trust

[615] Sentencia T-171/18, La Sala Séptima de Revisión de tutelas, Colombian Constitutional Court, 7 May 2018.

[616] Benjamin HAWKINS and Arturo ALVAREZ ROSETE, 'Judicialization and Health Policy in Colombia: The Implications for Evidence-Informed Policymaking' (2019) 47 Policy Studies Journal 953 and Camila GIANELLA, 'Does the Colombian constitutional court undermine the health system?' (2011) Chr Michelsen Institute Brief

the health policy or the authorities', given the bad quality of such authorities, and the levels of corruption. Understanding the potential reasons behind the judicial decisions in Colombia would require a similar qualitative analysis in the country, which is not available in the literature. Yet from the analysis of secondary data it is possible to establish some links between health care litigation and a widespread distrust in Colombian public authorities. This is what I briefly analyse in the next section.

8.1.5. Sociological factor: a context of inequality, distrust and violence in Colombia

Analogously to Brazil, Colombia is also a country of deep contrasts. On the one hand, it has a progressive and promising Constitution, which abounds in socio-economic rights provisions. On the other hand, the democratic institutions coexist with a context of high levels of violence[617] in the aftermath of a longstanding civil war, and a long tradition of authoritarian governments. All of that in a society with deep-seated poverty alongside high levels of inequality[618]. As Gargarella has pointed out in several of his works, the constitutionalism of Latin America, at large, was led by the elites who found in all-encompassing constitutions a way to conciliate the interest of different sectors – conservative and liberals[619]. The consequence of this movement is the same in Brazil, Colombia, Argentina and Chile – examples of a wider Latin American phenomenon: progressive (and extensive) constitutions

[617] Gonzalo SÁNCHEZ, *Nuestra guerra sin nombre: transformaciones del conflicto en Colombia* (Editorial Norma 2006)

[618] Leopoldo FERGUSSON, Carlos MOLINA, James ROBINSON *and others*, 'The long shadow of the past: political economy of regional inequality in Colombia' (2017) Documento CEDE , through a 200 year study of regional inequality in Colombia, the authors conclude that "regional inequality has been highly persistent despite the large changes that have taken place and the modernization of the society. We show that regional inequality is highly correlated with significant within-country differences in economic and political institutions, which are themselves highly persistent over the same period".

[619] GARGARELLA, *Latin American constitutionalism, 1810-2010: the engine room of the Constitution*, Roberto GARGARELLA and Christian COURTIS, *El nuevo constitucionalismo latinoamericano: promesas e interrogantes* (Cepal 2009)

which do not effectively entail material change to the quality of the public services offered to citizens, but which gives judges the formal legal tools to justify activism in socio-economic rights.

Alongside a complex context of institutionalised violence and unstable governmental leadership, a large number of Colombians believe there is widespread corruption in public sectors. According to the 2014 Americas Barometer, 60% of Colombians believed corruption to be widespread amongst public officials[620], and more than 50% believed that it got worse in 2019[621]. It is not surprising, thus, that the levels of distrust in Colombian public institutions are high. Numbers and indexes which show in unison the problem of distrust in public institutions abound.

According to the OECD's report from 2018[622], self-reported trust in government reached the low ranks of 27% in Colombia, the fourth lowest among Latin American countries – accompanied by the lowest, Brazil - and significantly below the LAC and OECD averages, 34% and 45% respectively. Furthermore, between 2007 and 2018 trust decreased in both Colombia and Brazil by 24 and 21 percentage points, respectively.

As per Latino Barometro, a yearly survey about perception of institutions in Latin America[623], interviewees were asked: "in general terms, would you agree that the country is governed by a few powerful groups which govern for their own benefit, or do they govern for the good of people?". 90% of Brazilians and 80% of Colombians replied that the country was governed by people who governed for their own private interests.

[620] Michael HAMAN, 'The Colombian anti-corruption referendum: Why it failed?' (2019) Colombia Internacional 175

[621] Transparency INTERNATIONAL, 'Global Corruption Barrometer: Citizen's View and Experience of Corruption' (2019)

[622] OECD, 'Government at a Glance', *The Palgrave Handbook of Indicators in Global Governance* (Springer 2018)

[623] Available at https://www.latinobarometro.org/latOnline.jsp, accessed on the 5th of January 2021.

In the same Latino Barometro's survey, a question about which are the most pressing problems in your country identified health as the option of 20% of Brazilian respondents, and 9.5% of Colombians. Whilst corruption was the elected pressing problem by 15,8% of Brazilians and 19.6% of Colombians. Furthermore, 83% of Colombians responded that they though income distribution in the country to be unfair or very unfair, whilst in Brazil that number represented 89% of interviewees. Regarding public services, when asked "which public services in your country are you most satisfied with, 22% of Colombians and 16% of Brazilians said public hospitals, 38% of Colombians and 23% of Brazilian chose public schools (the highest) and 23% of Colombians and 42% of Brazilians either didn't know or declared never have used public services.

The numbers presented by these surveys all point out to the same problem both in Colombia and Brazil: a widespread distrust in public institutions, a perception of social injustice and discontent with public services. These numbers are good indicators of the importance of understanding how distrust and perceptions of inefficiency, corruption and social injustice can influence socio-legal phenomena such as mass health care litigation. For example, for the Constitutional Court justice Cepada-Espinosa, citizens distrust in the government and a widespread perception of public administration inefficiency fuels judicial activism:

> Bearing in mind the above-described flaws in the political system, to which the traditional ineffectiveness of the public administration is added (an ineffectiveness which is both real and perceived by ordinary citizens), it is not surprising that people look to the Court in search of a State answer to their problems. The Court then is not meddling in every issue imaginable; ordinary citizens or political players are bringing their everyday problems to the Court, and the Court is then forced to adjudicate on a notoriously diverse range of subjects[624]

[624] Manuel José CEPEDA-ESPINOSA, 'Judicial activism in a violent context: The origin, role, and impact of the Colombian Constitutional Court' (2004) 3 Wash U Global Stud L Rev 529 681

My in-depth research about Brazil confirmed the general direction pointed out by these surveys, and added the nuances provided by the interviewees necessary to understand *how* these factors – distrust, perception of corruption, inefficiency and inequality – operate in the health care litigation phenomenon. In the same manner, Colombia would greatly benefit from an in-depth study of how sociological and legal factors operate in their phenomenon of successful health care litigation. For example, are in Colombia also lower instance court judges significant for generating high numbers of successful claims?

The perception judges have of other institutions and their professional identity construction, were two important factors behind Brazilian judges' decision to grant health care claims. Their disposition to disregard the statutory law (i.e., not analysing its provision in the decision) and health authorities' discretionary decision by using constitutional right's discourse is clearer with reference to these various sociological factors. In Colombia, the similar context might indicate an analogous construction for judges – i.e., judge's perception of a widespread corruption and inefficiency influence their disposition to grant health claims. Differently, in the United Kingdom judges do not display a similar disposition to override health care policy and specific regulatory decisions, i.e., the withholding of a particular treatment or drug to a particular patient, which is being challenged by a judicial review action.

Beyond the key differences in the constitutional doctrine of Parliamentary Sovereignty and the ultra vires model of judicial review in the British case, the different social context, and absence of the sociological factors encountered in the Latin American context - i.e., corruption, violence and extreme inequality –, might influence the relationship between institutions and the observed deference judges in the UK have towards the health authorities' decisions. This is what I briefly analyse in the next section of this chapter.

8.2. United Kingdom: a tale of judicial self-restraint and deference to the Minister for Health and Social Care and the NHS

The United Kingdom is a country with a much different history and social-economic context from Brazil and Colombia. Not only is the UK much richer but has also much lower levels of inequality[625] but also, since 1948, it created an integrated, universal, free health care system offered by the National Health Service (NHS). The NHS is the second largest single-payer health care system in the world, following just after the Brazilian system, SUS. The NHS is overseen by the Department of Health and Social Care and is primarily funded by general taxation and National Insurance contributions, offering comprehensive health care to all citizens and residents of the UK. The private voluntary health care system, which can be bought into by citizens is provided on a supplementary insurance base, is used by roughly 11% of the British population[626], and accounts for around 3.3% of the total health expenditure in the country[627].

The 2012 Health and Social Care Act delegated the allocation of resources to NHS England, which then commissions different organisations to provide health treatment around the country. Locally, the Clinical Commissioning Groups (CCGs), which substituted the Primary Care Trusts, plan and commission most of the hospital and community health care. Another central health institution, the National Institute for Clinical Excellence (NICE), was created in 1999 and later inspired the creation of a similar body in Brazil, the CONITEC. NICE provides the NHS with evidence-based clinical guidelines, develops quality standards and analyses the cost-efficiency of new drugs and treatments for inclusion in the national health

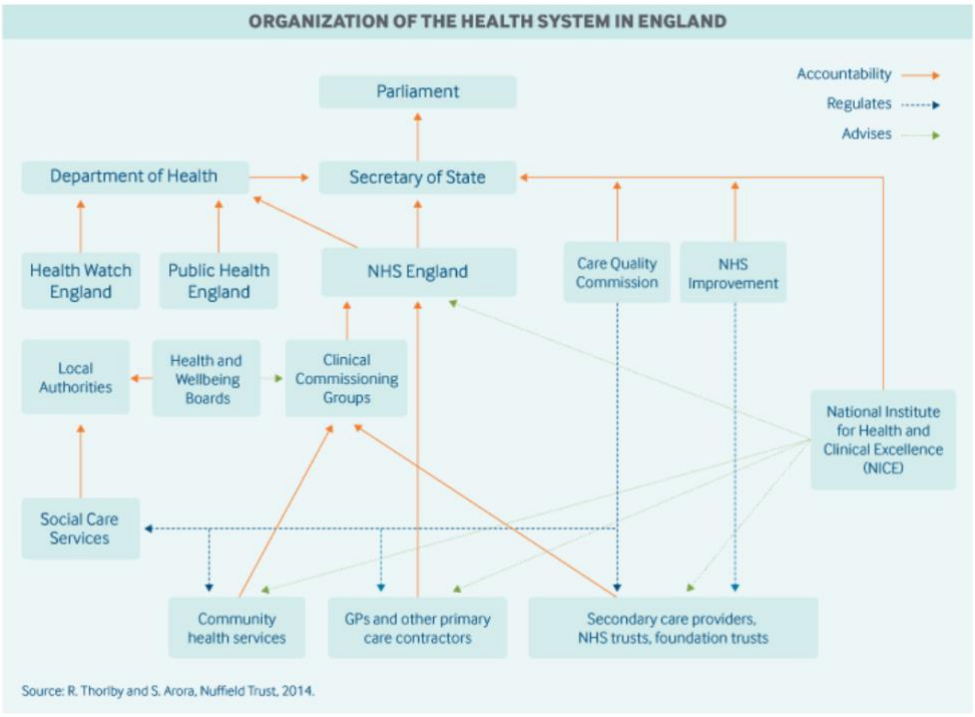
[625] According to the World Bank, the Gini index (which measures inequality from 0% - perfect equality – to 100% - maximal inequality) measured in the United Kingdom in 2016 was 34.8, in comparison to 53.9 of Brazil and 50.4 of Colombia.

[626] The Kings FUND, *The UK Private Health Market*, 2014)

[627] Roosa TIKKANEN, Robin OSBORN, Elias MOSSIALOS *and others*, *International Health Care System Profiles - England* (International Health Care System Profiles, 2020)

service. As part of NICE's appraisal process, interested groups such as patient's collectives and pharmaceutical companies can submit evidence to influence such decisions[628]. The figure below illustrates the structure of the British health system:

Figure 11: Organisation of the Health System in England



[629]

As I analyse further in section 8.2.2 below, the NHS is one of the most admired and trusted institutions in the UK and has been central to the political debate since its inception. Although the system has faced high rates of medical negligence lawsuits, access to health care litigation (or health resource litigation as it is also known) filed by patients is not that frequent. In fact, the first case requesting judicial review of a resource allocation in the UK only

[628] Robin E FERNER and Sarah E MCDOWELL, 'How NICE may be outflanked' (2006) 332 BMJ 1268

[629] TIKKANEN, OSBORN, MOSSIALOS *and others*, *International Health Care System Profiles - England*

happened in 1980[630] in *R v Secretary of State for Social Services, ex parte Hincks* (1980)[631]. Moreover, judicial review cases filed in the UK courts to challenge NICE's decisions to incorporate (or not) a drug to the NHS and the pricing fixed by the health authority are mostly started by pharmaceutical companies rather than patients[632]. Although these cases also exist in Brazilian courts, they are less frequent – although, as describe in Chapter 7, pharma companies provide the legal and financial resources to support patients' litigation. This interesting contrast between the UK and Brazil sheds into the different ways the judicial system is used in strong economic powers[633]. My focus in this thesis, however, is to understand the factors influencing patients' decision to start judicial cases against the public health care system. Therefore, I leave a deeper exploration of how pharmaceutical companies use the administrative mechanisms to challenge the administrative decisions in the UK and Brazil to a future analysis.

The cases of access to health care litigation by patients in the UK are not only rarer, but also receive a much different response from courts. In part, the uncommonness of cases may be attributed to the complexity of procedures and higher costs involved in starting litigation – which include, on top of lawyer and court fees, potential looser pay fees in cases of unsuccessful outcomes[634] - but also to the stronger administrative procedures at NICE and alternative dispute resolution methods to challenge an administrative decision, such as Parliamentary and Health Service Ombudsman. Furthermore, courts in the UK have historically exercised judicial restraint in reviewing decisions of the health authorities. This is what I analyse in the next section, starting by addressing how the case law has evolved in

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[630] Christopher NEWDICK, *Who Should We Treat?: Rights, Rationing, and the Resources in the NHS* (Oxford University Press Oxford 2005)

[631] *R v Secretary of State for Social Services, ex parte Hincks* (1980) 1 BMLR 93

[632] Richard BEST, 'Pharmaceutical subsidisation and judicial review of the National Institute for Clinical Excellence' (2001) 7 Journal of Commercial Biotechnology , Keith SYRETT, 'Nice and Judicial Review: Enforcing 'Accountability for Reasonableness' through the courts?' (2008) 16 Medical law review 127 and ---, 'Nice Work-Rationing, Review and the Legitimacy Problem in the New NHS' (2002) 10 Med L Rev 1

[633] GALANTER, 'Why the haves come out ahead: Speculations on the limits of legal change'

[634] Public Law PROJECT, *An Introduction to Judicial Review*, 2018)

British courts around cases discussing resource allocation for health care.

8.2.1 Legal factor: how do courts in the UK decide access to health care lawsuits

The central *legal* difference between how lawsuits for access to health care claims are treated in UK courts versus Brazil and Colombia lies in the legal apparatuses applied by judges in each country[635]. Whilst in the UK access to health care claims are mainly resolved under administrative law provisions, in Brazil and Colombia the same claims are treated as constitutional reviews – a fact that is even clearer in relation to Colombia, where the procedural instruments applied, the *tutelas*, can only be used in cases of constitutional violation.

As I explained further in Chapter 5, published judicial decisions in Brazil rarely discuss resource allocation, or even refer to the statutory law when deciding access to health care claims (i.e., judges often fail to apply the statutory law which regulates SUS, and the administrative provisions which set determine the drugs, treatment and devices offered by the system). Moreover, most Brazilian judges restrict their legal reasoning to the application of constitutional provisions – in this case articles 6 and 196 of the Brazilian Constitution – in order to justify granting drugs, treatments or medical devices not provided by the public health care system. In Colombian courts we observe a similar pattern.

In turn, the UK courts have comparatively exercised wider restraint in deciding judicial review cases. For a long time, the public law system of the United Kingdom was felt to lack instruments to control the administrative bodies of the State[636]. Dicey believed that the 'enlightened England' did not require a body of Administrative Law such as that developed by

[635] Evidently, there are important differences of the systems of the UK (common law and Parliamentary Sovereignty) and Brazil and Colombia (civil law systems), which also play a key role in how judicial review is exercised in the three countries.

[636] TT ARVIND and Lindsay STIRTON, 'The curious origins of judicial review' (2017) Law Quarterly Review

the administrative courts in continental Europe[637]. In his words: "[T]he words 'Administrative Law' (…) are unknown to English judges and counsel and are in themselves hardly intelligible without further explanations"[638]. A few decades past, the enactment of the Human Rights Act (1998) raised concerns about how judges would enforce human rights standards, threatening the preservation of a key feature of the UK legal system: parliamentary sovereignty[639]. Such concerns were then alleviated by a model of review for fundamental rights that enables the courts to only provide 'a declaration of incompatibility' in the case of finding primary legislation under which e.g., powers of a health care provider may be exercised, in breach of a fundamental right.

Under the modern model of judicial review in the UK, courts are able to declare that there is a violation of a human rights provision when reviewing legislation, but Parliament is under no obligation to change the law[640]. This means that the British legislator is allowed to enact primary legislation which contravenes human rights provisions, even if the Judiciary provides a declaration of incompatibility (section 4 of the Human Rights Act[641] with limitations of section 19 of the same instrument[642]). Whilst the goal of this chapter is not to dive into a complex discussion about the extent of the UK Judiciary's power to enforce human rights

[637] Justice GLIDEWELL, 'English Administrative Law: Past, present and future' (1993) 15 Liverpool Law Review 3

[638] Albert Venn DICEY, *The law of the constitution*, vol 1 (Oxford University Press 2013)

[639] Aileen KAVANAGH, 'What's so weak about "weak-form review"? The case of the UK Human Rights Act 1998' (2015) 13 International Journal of Constitutional Law 1008

[640] According to §3 of the Human Rights Act: "So far as it is possible to do so, primary legislation and subordinate legislation must be read and given effect in a way which is compatible with the Convention rights" (Human Rights Act, 1998, c. 42, § 3(1) (U.K))

[641] §4 provides for: (2) "If the court is satisfied that the provision is incompatible with a Convention right, it may make a declaration of that incompatibility" and (6) A declaration under this section ("a declaration of incompatibility") — (a)does not affect the validity, continuing operation or enforcement of the provision in respect of which it is given; and (b)is not binding on the parties to the proceedings in which it is made" (Human Rights Act, 1998, c. 42, § 4 (U.K.)).

[642] §19. Statements of compatibility. (1)A Minister of the Crown in charge of a Bill in either House of Parliament must, before Second Reading of the Bill - (b)make a statement to the effect that although he is unable to make a statement of compatibility the government nevertheless wishes the House to proceed with the Bill ((Human Rights Act, 1998, c. 42, §19 (U.K).

provisions against the State, understanding the historical development of parliamentary sovereignty and its effect on judicial review (and judicial restraint) helps in contrasting litigation for access to health care in the UK and Brazil.

Moreover, whilst in Brazil and Colombia constitutional rights such as health, life and human dignity, are central to the judicial legal reasoning enabling access to drugs, treatments and medical devices not offered by the health care system, in the UK similar claims are not decided under human rights provisions. Rather, as I briefly explain in this section, courts have historically addressed access to health care claims – also referred to by the literature as health resource allocation litigation, strictly from an administrative angle, applying different tests to assess the health authorities' or minister's decisions. By briefly analysing six high court and court of appeal decisions – considered as key decisions discussing access to health care by the literature[643] - I will show that not only are successful cases requesting access to health care in British courts much rarer, but even when successful, courts still display a higher degree of judicial restraint on reviewing allocation decisions. Finally, I will discuss how in the vast majority of cases judges opt to not use human rights.

In an in-depth study of the evolution of English case law involving access to health care cases, Daniel Wang[644] explains that initially (from 1980s until mid-1990s) courts limited the scope of health authorities' judicial review to the application of the 'Wednesbury unreasonableness' test. This meant only allowing for judicial review to be carried out when the administrative decisions were considered 'absurd', 'outrageous in their defiance of logic or accepted moral standards'[645].

[643] Keith SYRETT, 'Deference or deliberation: rethinking the judicial role in the allocation of healthcare resources' (2005) 24 Med & L 309 and Christopher NEWDICK, 'Judicial review: low-priority treatment and exceptional case review' (2007) 15 Medical law review 236

[644] Daniel Wei L WANG, 'From wednesbury unreasonableness to accountability for reasonableness' (2017) 76 Cambridge LJ 642

[645] NEWDICK, *Who Should We Treat?: Rights, Rationing, and the Resources in the NHS*

According to the literature, the judicial choice of the Wednesbury approach rendered judicial control of health resources allocation as analysis of mere 'technicalities' rather than a review of substantive principles of administrative law[646] (albeit some have criticised the test as a way to authorise the review the merits of administrative decisions[647]). In the first few cases filed in British courts to challenge the NHS' policies decisions not to offer medical treatments, judges displayed a substantive deference to the administrative decision, engaging in minimum scrutiny of the allocative choices made by health authority.

> The court's reasoning was straightforward: resources are scarce, not all health needs can be met, and thus rationing is necessary; and health authorities are best able to do this. On this basis, the courts determined that they had no reason to review rationing decisions unless they were 'Wednesbury unreasonable', i.e., so absurd or outrageous in their defiance of logic or morality that no reasonable person addressing the question would have come to the same conclusion.[648]

For instance, in 1980, the first judicial review case was brought against the Secretary of State for Social Services in 1980, whereby the claimant, Hincks, requested access to an orthopaedic surgery that had been postponed for a year due to lack of resources. The claim was denied by the English High Court, and later confirmed by the Court of Appeal, who accepted the defendant's argument that the lack of financial resources prevented the hospitals and health facilities to meet every citizen's demand. According to the Court of Appeal:

> They (claimants) share the misfortune with thousands up and down the country. I only hope that they have not been encouraged to think that these proceedings offered any real prospects that this court could enhance the standards of the National Health Service, because any such encouragement would be based upon manifest illusion. [649]

[646] Jeffrey JOWELL and Anthony LESTER, 'Beyond Wednesbury: Substantive principles of administrative law' (1988) 14 Commonwealth Law Bulletin 858

[647] Michael TAGGART, 'Proportionality, Deference, Wednesbury' (2008) NZL Rev 423 and Jeffrey JOWELL, 'In the Shadow of Wednesbury' (1997) 2 Judicial Review 75.

[648] WANG, 'From wednesbury unreasonableness to accountability for reasonableness'

[649] R v Secretary of State for Social Services and Ors ex parte Hincks [1980] 1 BMLR 93, p. 97, op cit Daniel Wei Liang WANG, 'Can Litigation Promote Fairness in Healthcare?', London School of Economics 2013) 119

The strict judicial deference given by British courts to the health care authorities' discretion was observed until *R* v *Cambridge Health Authority, ex p B*[650] in 1995. The case, which discussed the access of a child suffering from non-Hodgkins lymphoma and myeloid leukaemia to an experimental treatment, was accepted by the High Court under the application of the 'Wednesbury unreasonable' test. The High Courts' judgement, which quashed the administrative decision of the Cambridge Health Authority, applied section 3 of the National Health Service Act of 1977, and the 'fundamental right to life' as persuasive legal authority. However, the judgment was overturned by the Court of Appeal, who returned to the judicial deference observed by British case law until then. In the words of Sir Thomas Bingham:

> I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make. In my judgment, it is not something that a health authority such as this Authority can be fairly criticised for not advancing before the court. [651]

The approach of British courts to review health authority decisions slowly changed from 'judicial passivity' to a 'hard look'[652], whereby the burden to prove the reasonableness of

[650] R v Cambridge Health Authority, ex p B [1995] 2 All ER 129, [1995] 1 WLR 898

[651] [1995] EWCA Civ 49, pg. 8.

[652] Keith SYRETT, 'Healthcare resource allocation in the English courts: a systems theory perspective' (2019) 70 Northern Ireland Legal Quarterly 111

decisions was placed on the authority rather than the claimant[653]. However, even when granting claims British courts still displayed a high level of deference and restraint in exercising public powers in individual cases.

For example, in *R* v *North West Lancashire Health Authority*[654], a case which discussed access to gender reassignment surgeries, the decision of the High Court, later upheld by the Appeal Court, declared the decision of the health authority irrational for not considering transsexualism an illness. However, as a consequence of the legal interpretation, it did not condemn the authority to perform the surgery (similarly to what would happen in cases in Brazil or Colombia), but rather established the legal parameters – transsexualism as an illness – for the health policy to be developed in accordance with it. In verbis:

> For those reasons I would quash the Authority's 1995 and 1998 Policies insofar as they concern gender reassignment treatment and the decisions the subjects of this appeal based on them and remit the matter to the Authority for reconsideration of its policy and the decisions on their individual merits. The Authority should reformulate its policy to give proper weight to its acknowledgement that transsexualism is an illness, apply that weighting when setting its level of priority for treatment and make effective provision for exceptions in individual cases from any general policy restricting the funding of treatment for it[655].

The same deferential approach to judicial review of health authorities' decisions given in *R v North West Lancashire Health Authority* is observed until this day in British courts. The same pattern of decision-making was followed, for example, in the famous *Ann Marie Rogers v Swindow Primary Care Trust & Secretary of State for Health*[656], in which the claimant requested access to an adjuvant breast cancer drug, trastuzumab (Herceptin).

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[653] WANG, 'From wednesbury unreasonableness to accountability for reasonableness'

[654] R v North West Lancashire Health Authority, ex parte A and Others [1999] EWCA Civ 2022

[655] [1999] EWCA Civ 2022

[656] *Ann Marie Rogers v Swindow Primary Care Trust & Secretary of State for Health* [2006] EWCA Civ 392

In Rogers, the Court of Appeal understood that the decision taken by the health authority, which analysed the exceptionality of her condition and denied access to the cancer treatment, was irrational and therefore unlawful. Nonetheless, similarly to *R v North West Lancashire Health Authority*, the successful outcome of the litigation did not result in the Court ordering the Trust to fund Ann Marie's treatment, but to 'reconsider its policy and to formulate a lawful policy upon which to base decisions in particular cases, including that of the appellant, in the future'[657]. Furthermore, the court issued a caveat in which it confronted the legitimacy[658] of the rationing decision by the primary care trust, stating that if the authority had reached the same conclusion based on cost decision and not exceptionality of the case, it would have probably not been reverted by the Judiciary:

> If that policy had involved a balance of financial considerations against a general policy not to fund off-licence drugs not approved by NICE and the health care needs of the particular patient in an exceptional case, we do not think that such a policy would have been irrational.[659]

More recently, in 2016, the English Judiciary was called to decide a claim brought by the High Court reviewed the Nation Aids Trust against the NHS England discussing the inclusion of a prophylactic anti-retroviral drug, known as PrEP, in the national health service[660]. According to the NHS, the statutory law governing the national health service (National Health Service Act 2006) did not confer legal power to the NHS England to commission preventive treatment, but rather it attributed it to local authorities and the Secretary of State. The law would thus prevent NHS England to commission the preventive anti-

[657] [2006] EWCA Civ 392

[658] NEWDICK, 'Judicial review: low-priority treatment and exceptional case review'

[659] [2006] EWCA Civ 392 at 73

[660] Trust v National Health Service Commissioning Board (NHS England) (Rev 1) [2016] EWHC 2005 (Admin) (02 August 2016)

retroviral drug requested by the claimants. However, by applying the *ultra vires* doctrine, the High Court disagreed with such interpretation of the NHS Act 2006. According to Justice Green, NHS England 'erred in deciding that it had no power or duty to commission the preventive drugs in issue'[661]. The Court concluded that NHS England has the power to commission for preventive purposes – including HIV related drugs. By virtue of Section 2 NHSA 2006[662], the Court understood that the law empowers the NHS England 'to "to do "anything" which is calculated to facilitate or is conducive to or incidental to the discharge of any of its functions'[663].

As an outcome of the PrEP litigation, today the preventive drug is available to all users of the NHS for free – subject to analysis of the sexual health clinics. However, the inclusion of PrEP in the NHS was not an order of the High Court, but rather the action of a reviewed analysis of NICE following the legal interpretation given by the Courts to the legislation.

Moreover, it can be noticed that even in successful cases, courts still respect the discretion of health authorities, by applying strict administrative legal standards which also limit the scope of judicial activity (i.e., ultra vires doctrine). Meanwhile, the lack of similarly dense legal net of standards for judicial review in Brazil, and the use of an all-encompassing constitutional reasoning to justify quashing administrative decisions, leaves a wide door to the exercise of judicial activism in the Latin American countries.

8.2.2 Avoiding human rights as legal reasoning for judicial review in health care

[661] [2016] EWHC 2005 at 6

[662] Section 2A(1) of the NHS Act 2006 provides for: 'A Secretary of State's duty as to protection of public health (1)The Secretary of State must take such steps as the Secretary of State considers appropriate for the purpose of protecting the public in England from disease or other dangers to health.'

[663] [2006] EWCA Civ 392 at 84

Still in relation to the legal factors driving successful health care litigation, another essential difference between the legal instruments used by British courts and Brazilian/Colombian courts is the relevance of human rights provisions to justify granting access to health care. In fact, courts in the UK have either not addressed human rights claims at all when deciding health allocation lawsuits, or expressly rejected the application of human rights provisions – such as the right to life. For example, in the *R v North West Lancashire Health Authority*, when analysing the applicability of human rights provisions, Lord Justice Auld understood that considering the European Convention of Human Rights – which was not yet part of the domestic UK law – would be 'positively unhelpful, cluttering up its consideration of adequate and more precise domestic principles and authorities governing the issues in play'[664].

Although on a few occasions the High Court has used the 'fundamental right to life' to justify reviewing the health authorities'[665], such as in *R v Cambridge Health Authority Child B*), the decision was later overturned in the Court of Appeal, and the human rights reasoning was set aside for the application of a reasonableness test.

In *AC vs Berkshire West Primary Care Trust (2010)*[666], the High Court briefly assessed the claimant's allegation of human rights violation, but to reject its application. *In casu*, the claimant, who suffered from gender identity disorder and was undergoing hormonal treatment, started legal action against the Berkshire West PCT requesting funding for breast augmentation surgery. She argued that breast augmentation had been funded by the NHS in cases where a 'natal woman who is suffering mild to moderate depression because she perceives that her breasts are inadequate'[667], therefore making the PCT's rejection to fund her plastic surgery a

[664] *R v North West Lancashire Health Authority* [1999] EWCA Civ 2022

[665] *R v Cambridge Health Authority Child B*) [1995] EWCA Civ 49

[666] AC v Berkshire West Primary Care Trust [2010] EWHC 1162 (Admin) (25 May 2010)

[667] [2010] EWHC 1162 at 35

case of discrimination (article 14 of ECHR[668]) and breach of right to health (article 8 of ECHR[669]). Nonetheless, in a brief paragraph the High Court rejected the claim that there had been a breach of the claimant's human rights, by stating that

> Auld LJ's observation that Article 8 of the ECHR imposes no positive obligation to provide treatment is still good law: see *per* Mitting J in *A v West Middlesex University Hospital NHS Trust*[670] *(...)*. Even in combination with Article 14, Article 8 does not in my view add to Ms. Harrison's arguments.

The restraint of UK courts is seen by some, such as Syrett[671] and Allan[672], as a lost opportunity to give health authorities more transparency and accountability in their rationing decisions. The deference observed in UK courts, however, is lacking in Brazil and Colombia. In the next section I address one of the sociological factors underpinning access to health care litigation in Brazil and Colombia in order to see if we can establish some parallels with the British experience: trust.

8.2.3. Can trust in the NHS be understood as sociological deterrence of successful health care litigation?

Central to the interviews conducted in Brazil was a discourse that connected the rise of successful health care litigation with a widespread perception that the health care system is not

[668] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended, (ECHR) art 8 (2).

[669] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended, (ECHR) art 14

[670] In Article 8 of the Convention does not impose on a Convention state the obligation to provide medical treatment at any specific level to persons within its territory (see Tysiac v Poland 5410/03, 20th March 2007, paragraph 107). That statement of principle by the Strasbourg Court finds a clear echo in the decision of the House of Lords in N v Secretary of State for the Home Department [2005] 2 AC 296" ([2008] EWHC 855 at 31).

[671] SYRETT, 'Impotence or Importance-Judicial Review in an Era of Explicit NHS Rationing' and ---, 'Deference or deliberation: rethinking the judicial role in the allocation of healthcare resources'

[672] Trevor RS ALLAN, 'Human rights and judicial review: a critique of due deference' (2006) 65 Cambridge LJ 671

well managed in Brazil, that the administration is inefficient and/or corrupt. Interviewees connected the distrust in the Brazilian public sector, the policy makers and specially in politicians, to the need to find solutions for health issues elsewhere – in the Judiciary. A utilitarian trust in a successful outcome of the case to be delivered by a judge. Such distrust was met in courts by judge's empathy towards litigants, a personal empowerment to fix a perceived wrong situation and "do good", and a distrust towards the administration's defence. In Colombia, as briefly analysed above, we identify a similar sociological situation: strong courts, with empowered individual judges who are able to order the health authority to grant a treatment not included in the policy, a widespread distrust in public institutions and discontent with the health system.

Both Brazil and Colombia share the same post-colonial background of patrimonialism and concentration of power, a deeply unequal society and high numbers of individual lawsuits against health authorities for access to drugs, treatments and devices not provided. The United Kingdom's background is much different. A country which was not colonised but a coloniser, which endures a much older and more stable democracy. Furthermore, since the end of the second world war the UK has established its most respected institutions: the NHS.

According to a research conducted by YouGov in 2018[673], the two institutions which UK citizens are most proud of are the Fire Brigade (91%) and the National Health Service, NHS (87%). The NHS also comes out as the most trusted public institution in a survey conducted in 2019[674]. And yet, improving health care is still considered the most important

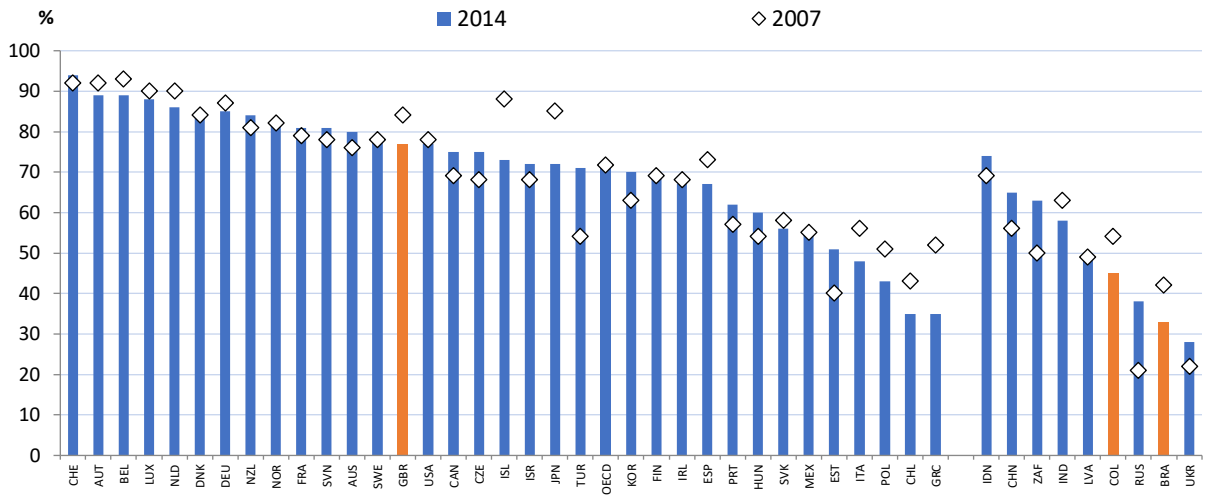
[673] Available at https://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/01kiz0vf72/InternalResults_180629_British_Institutions_w.pdf, accessed on 10th of January, 2021.

[674] Synergy, BAME Charity Survey, Nov. 2019-Jan.2020, available at https://nfpsynergy.net/blog/bame-population-charity-engagement, accessed on 15th of January, 2021.

issue for British citizens[675].

As the Figure 12 below shows Colombians' and Brazilians' satisfaction of the health care system is considerably lower than the United Kingdom, and the average of OECD countries. Comparing levels of satisfaction can be helpful towards understanding trust, as per the definition of trust I provide in Chapter 3, according to which trust arises from the realisation of someone's expectation.

Figure 12: Citizens Satisfaction with public health care system (2007 and 2014)



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Interestingly, the respect of British people for the NHS – signposted above by the different quantitative surveys on institutional trust – also appears to be a factor influencing potential litigants' decision to start legal claims. For example, a research about the drivers of

[675] According to Edelman Trust Barometer from 2020, 85% of UK respondents thought improving health care was important and 60% thought it was very important. And 49% were unsatisfied with progress on improving quality and accessibility of health care services.

[676] OECD, *Trust in government* (2015)

litigation in health services in the UK showed that potential litigants – especially older ones - also displayed a higher degree of resistance for starting claims against the NHS. According to one paralegal interviewed:

> People almost used to be embarrassed, certainly older people. When they used to tell me things they'd say, 'You know, I don't want anyone to know I'm doing a claim because I don't want anyone to think bad of me for suing the NHS because they're brilliant.' (…) it was almost taboo to make a claim against the NHS and it was frowned upon.[677]

Such worry about the negative implications of starting litigation against the NHS does not find a parallel in the Brazilian case. On the opposite. As I analyse in Chapter 6, interviewed litigants in Brazil demonstrate a utilitarian approach to litigation, as the "only" or easier option to get access to the drug, treatment or medical device required, which was also accompanied by a distrust in the quality of the health care policy and the intention of the policy makers to offer good quality health services to the population.

8.3. Conclusion

In this chapter I compared factors that help to explain a significant increase in successful health care claims with features of health care litigation in Colombia and the UK, including legal and to some extent sociological factors explaining how much litigation is used and why.

By focusing on two main factors of legal and sociological nature – i.e. nature of the legal reasoning used by judges to grant health care claims, as well as legal structures, such as the different legal features of an administrative law claim, the tutela in Colombia on the one

[677] Yvonne BIRKS, Fiona ASPINAL and Karen BLOOR, 'Understanding the drivers of litigation in health services' (2018) The Kings Fund, University of York

hand, and the action for judicial review in the UK, on the other hand, and trust in the health care system, respectfully – I highlight the importance of understanding health care litigation as a complex phenomenon which is driven by both legal and sociological factors.

The Colombian experience with health care litigation is, in more ways than few, comparable to the Brazilian one. The Colombian Constitution expanded the reach of the *tutelas* to encompass health care claims, allowing for a speedy and affordable treatment of legal claims seeking access to drugs, treatments and medical devices. Meanwhile, British courts display a much higher level of deference towards administrative decisions.

On the one hand, the constitutionalisation of rights seems to be, both in the Brazilian and Colombian experiences, a central legal driver enabling the rise of successful litigation for access to health care. On the other hand, in the UK judicial review is centred around administrative legal analysis, and the application of reasonableness tests as well as whether relevant considerations have been considered to the specific decisions. Moreover, UK courts are reluctant of reviewing policy decisions with reference to human rights provisions.

From a sociological perspective, while the legal spark of the constitutionalisation of rights in Colombia and Brazil sets on fire the fuel spread by a sociological context of distrust and inequality, in the UK the low rates of litigation may be linked also to high levels of trust and satisfaction with the NHS.

Finally, stresses the importance of further socio-legal investigations about health care litigation and judicial activism, with a particular focus on lower court judges. By researching the literature about litigation for health care in Colombia and Brazil, one easily notices the overwhelming focus on the Supreme and Constitutional Courts – even though lower court judges have the power to exercise constitutional control (via constitutional judicial review).

CHAPTER 9 - CONCLUSION: UNTANGLING THE COMPLEX WEB OF SOCIO-LEGAL FACTORS INFLUENCING LITIGATION FOR ACCESS TO HEALTH CARE IN BRAZIL

Amidst the global Covid-19 pandemic, the Brazilian government lead by President Jair Bolsonaro was the target of international criticism for underplaying the severity of the pandemic and expressly opposing vaccination. But at the same time, the Judiciary has been a central player by reviewing the policy response to Covid-19 around the country. For example, in October 2020, responding to the federal governments' efforts to stall vaccination, the Brazilian Supreme Court decided that imposing mandatory vaccination is constitutional under the 1988 Constitution[678]. In December of the same year, the Supreme Court determined that states would be free to distribute vaccines which had not been approved by the health and safety agency, ANVISA, if the agency took more than 72h to analyse the request for authorisation of vaccines.

Meanwhile, at the state level, a federal judge from the Amazon state – where patients suffocated due to the lack of oxygen in public hospitals - determined that citizens caught cheating the vaccination queue, would be banned from taking a second dose. And in São Paulo, a first-degree judge demanded that the list of vaccinated people be made public, to increase transparency and surveillance of how the priority vaccination lists are being applied. In March 2021, a first-degree judge from Franca, in the countryside of the state of São Paulo, ruled that the lockdown imposed by the mayor was 'useless' and rendered void the municipal authority's decision to close commercial establishments[679].

[678] ARE 1267879, Rapporteur Justice Luís Roberto Barroso, Supreme Court, Brazil (17/10/2020)

[679] MS n. 1000011-02.2021.8.26.0608/Franca**,** Judge Charles Bonemer Junior, State Court of the State of São Paulo, 21/3/2021.

The examples of judges around the country reviewing administrative and government decisions during the Covid-19 pandemic abound. This specific discussion of the role of the Judiciary in the control of the public health policy in relation to Covid-19, is, however, part of a much wider debate about judicialisation of access to health care in the country.

The Brazilian Constitution of 1988, enacted in the aftermath of a military dictatorship which stripped many Brazilians of their individual rights and freedoms, is one of the examples of the wave of constitutionalisation of rights observed in post-authoritarian democracies around the world[680] – and particularly in Latin America[681]. Amongst the extensive list of individual and collective rights, the Constitution of 1988 also established health as a fundamental, justiciable right.

According to articles 6 and 196[682] of the Brazilian Constitution, every Brazilian has the right to access universal and equitable health, provided free of cost by the State through the SUS – *Sistema Único de Sáude.* According to the law n. 8080/90, which regulates the SUS, all three levels of the State (municipalities, federal states, and the union) are jointly liable for providing universal and equitable health to all Brazilians. Furthermore, as a justiciable fundamental right, the Brazilian Constitution also gave Brazilians the right to seek judicial action if (s)he had her/his fundamental right to health breached.

In parallel, the 1988 Constitution also enabled an expansion of judicial powers in Brazil by widening the door of access to courts. This included strengthening bodies of legal aid[683], such as the public defender's office, lowering costs of litigation – including through the

[680] HIRSCHL, 'The Political Origins of Judicial Empowerment through Constitutionalization'

[681] GARGARELLA, *Latin American constitutionalism, 1810-2010: the engine room of the Constitution*

[682] Federal Constitution 1988, Brazil.

[683] Luiz Eduardo Pereira MOTTA, Marco Aurélio RUEDIGER and Vicente RICCIO, 'O acesso à Justiça como objeto de política pública: o caso da defensoria pública do Rio de Janeiro' (2006) 4 Cadernos EBAPE BR 01; Ana Carvalho Ferreira Bueno de MORAES, 'A Defensoria Pública como instrumento de acesso à justiça' (2009)

increasing exemption of legal fees (*justiça gratúita*)[684], widening the judicial review powers of all judges[685], and broadening the list of justiciable socio-economic rights in the Constitution[686]. Consequently, since the 1990's Brazilian courts have observed a sharp increase of litigation and judicial activism[687], particularly in regard to the expansion of individual civil and political rights and social-economic guarantees. This phenomenon, coined as the 'judicialisation of life'[688] by the Supreme Court Justice Luís Roberto Barroso, is also exemplified by the litigation of health rights.

The judicialisation of health, as the phenomenon, spreads in Brazil during the 90s with litigation seeking access to HIV treatment. With the successful outcome of those claims, the continued expansion of legal aid services (such as the public defender's office and the small claims courts), and the "sympathy" of judges for access to health claims expressed in the high rates of decisions granting the litigants' requests, the judicialisation of health became a mass litigation[689] phenomenon where all sorts of drugs, treatments and medical devices are given access to through judicial decision.

To this day Brazilian judges decide millions of lawsuits filed against the state and private insurance companies for access to drugs, treatments and medical devices not provided

[684] Wilson Fernandes PIMENTEL, 'Acesso responsável à justiça: o impacto dos custos na decisão de litigar' 2017); Gabriela de Campos HÖWELER, 'O benefício da justiça gratuita no processo do trabalho após a Lei 13.467/17: uma análise sob o prisma do acesso à justiça' (2019)

[685] ROSENN, 'Judicial review in Brazil: Developments under the 1998 Constitution'; Marcos Paulo VERISSIMO, 'A constituição de 1988, vinte anos depois: suprema corte e ativismo judicial" à brasileira"' (2008) 4 Revista Direito GV 407; Luiz Werneck VIANNA, Marcelo Baumann BURGOS and Paula Martins SALLES, 'Dezessete anos de judicialização da política' (2007) 19 Tempo social 39

[686] Luís Roberto BARROSO, 'Judicialização, ativismo judicial e legitimidade democrática' (2009) Anuario iberoamericano de justicia constitucional 17

[687] Oscar Vilhena VIEIRA, 'Supremocracia' (2008) 4 Revista Direito GV 441

[688] BARROSO, 'Judicialização, ativismo judicial e legitimidade democrática'

[689] The issue of mass and repetitive litigation is widely explored in the legal literature with regards to tort cases, class actions and joinder mechanisms (COOPER, 'Mass and Repetitive Litigation in the Federal Courts'; STIER, 'Resolving the Class Action Crisis: Mass Tort Litigation as Network').

by the national health care system, SUS. In 2018 alone, out of a total of 32 million cases adjudicated by Brazilian courts[690], over two million cases were health care related[691]. Furthermore, from 2008 to 2017, the number of lawsuits for access to health care skyrocketed, seeing an increase by 130%[692].

This massification of health care litigation is a burden not only on courts, which become overloaded, but to the public health care administration itself. For instance, the multiplication of individual litigation against the SUS has had a profound impact on the public budgetary system and the management of the health care policy by the Executive. As an example, the Brazilian Ministry of Health estimates that out of the R$125 billion (circa £20bilion) destined to fund the public health care system in 2017, R$7 billion (circa £1.2billion) were spent on complying with judicial decisions.[693]

It is undisputed that the massification of access to health care services litigation in Brazil has created an overbearing burden on the public budget and the Judiciary and there is very good evidence that it widens the inequality gaps between users of private and public health system. Litigation produces a tension on rationing of delivery for publicly funded healthcare; On one hand the rationing exercised by the administrative authorities responsible for implementing the public policy (including Anvisa, Conitec and the state authorities). On the other hand the rationing exercised at the judicial door, which offers to those who are able to access it, the privilege of cutting queues for treatments and accessing high-cost drugs not available to the wider public. These two are not connected or coordinated, and are in tension as they reach different and conflicting outcomes.

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[690] Conselho Nacional de Justiça (CNJ), *Justiça em Números* (2018)

[691] DE AZEVEDO, ABUJAMRA and ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução*

[692] Ibid

[693]Available at http://www.saude.gov.br/noticias/agencia-saude/25275-ministro-da-saude-fala-sobre-impacto-de-acoes-judiciais-no-sus

The judicial route is facilitated by access to courts in individual claims and by the wording of the Constitution, which judges have chosen to interpret widely. The commodification[694] of access to health care via courts also incentivises the development of a litigation market which involves specialised attorneys, patients' association and pharmaceutical companies. The system, therefore, is inherently unstable, and not progressive in delivering a balanced and sustainable solution of access to health care to all Brazilians, equitably – as the Constitution intended.

There is no shortage of legal and empirical literature exploring this topic in Brazil, and comparative analysis with other countries[695]. My research is situated into the literature that provides socio-legal accounts for the rise in successful health care litigation Brazil. The primary objective of this thesis in not to be a normative assessment of how fair or unfair the health care litigation phenomenon is – as a good part of the literature provides that analysis already – or to provide normative prescriptions. Rather, I offer an analytical explanatory framework of how interrelated internal and external factors influence the rise of successful health care claims in Brazil.

As explained further in Chapter 1, I drew on a grounded theory approach, through an in-depth analysis of the original qualitative empirical data collected in Brazil from 2016 to 2017. The data is comprised of 55 anonymised, semi-structured interviews with actors involved in health care litigation – including judges from all levels of jurisdiction, litigants who won and lost, private and public State's attorneys, civil servants from the Ministry of Health and State Health Secretaries, medical doctors, prosecutors and representatives of patients' associations

[694] As explained in Chapter 6, I use to concept of commodification to explain how the health care and litigation are treated as products/commodities by Brazilians in the context of the health care litigation phenomenon. (HENDERSON and PETERSEN, *Consuming health: The commodification of health care*).

[695] A quick search on *Google Scholar* using the terms 'judicialisation of health care Brazil', in Portuguese, (*judicialização da saúde Brasil*) results in over 19,500 academic publications (searched on 11th of November 2019).

and the pharmaceutic industry. The overarching focus of these interviews was to understand how the socio-legal factors drive litigants' and judges' decision-making process to start and grant health care claims.

The interviews help understand how these actors comprehend the massification of successful lawsuits for access to health care in the context of the Brazilian society; how they describe it; what they think are the main reasons for it, and why they decided to take a particular action. These personal accounts revealed important aspects of the actors' legal consciousness in relation to the right to health care, access to justice, separation of powers, as well as trust and the role of judges in Brazilian society. These personal accounts also disclosed, as I explored throughout chapters 4 to 8, wider social patterns as informing the phenomenon of successful mass litigation for health care, such as how Brazilians perceive and relate to the public sphere, in a postcolonial context and how a widespread distrust in politics and public institutions in Brazil leads judges to disregard the Executive's public health care policy. Finally, the interviews also revealed how the economic interest of powerful pharmaceutical companies, added to the interest of private attorneys and the patients' need to access health care, and the patients' utilitarian approach to trusting the Judiciary, incentivised the development of a private and individualist litigation apparatus designed to access public resources through litigation.

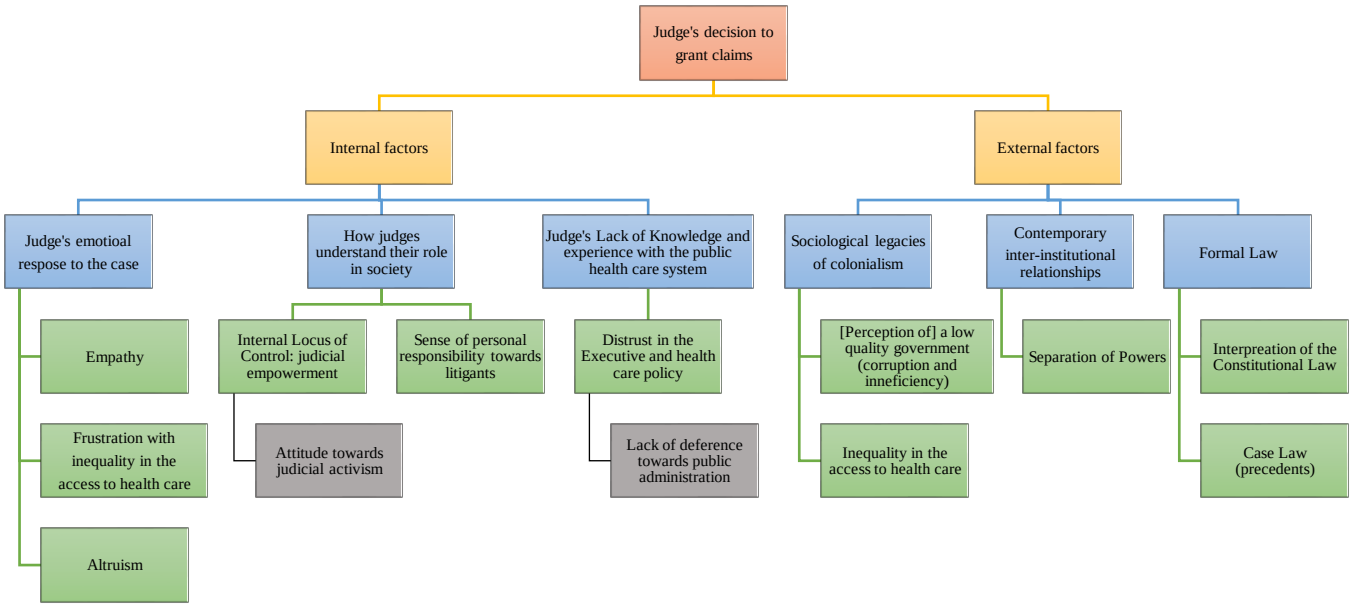
Mainly, the key finding taken from the interviews undertaken in Brazil is that the health care litigation phenomenon is a complex web constituted by both linked sociological and legal factors.

Key Finding: a web of socio-legal factors

The main outcome of my research is a middle-range theory about the links between internal and external socio-legal factors that drive the health care litigation phenomenon in

Brazil. The first main finding is, as stated above, that the health care litigation phenomenon in Brazil is a complex socio-legal phenomenon which combines factors of various natures: historical, sociological, personal and legal. My key argument is that these internal and external socio-legal factors depend on and reinforce one-another. The diagram below analytically summarises these factors:

FIGURE 13: SOCIO-LEGAL FACTORS THAT INFLUENCE JUDGE'S DECISION-MAKING DECISION TO GRANT A CLAIM



Regarding the internal factors identified, the interviewed judges explained their decision to grant claims against public authorities in favour of litigants seeking access to drugs, treatments and devices, firstly because they distrust the health care public policy, and could not rely on the competency and ethics of the policy maker - and of Brazilian politicians more widely - to define which treatments, drugs and medical devices should be available to citizens. Furthermore, judges described having the necessary legal and institutional power to decide the cases, which would authorise them to force public authorities to provide the drugs, treatments

and medical devices requested. In other words, judges recognised themselves in a position (locus of control) to exercise their legal and institutional power against Executive authorities. This empowerment was often referred to by judges as the "power of the cloak" or "power of the pen". The locus of control was also closely connected to judges feeling emotionally impacted by the individual claims brought before them. The idea was that as powerful public authorities in a country marked by deep contrasts and social inequality, they had a social obligation to positively affect the lives of Brazilians by enforcing socio-economic rights such as a right to health care. Several judges felt personally responsible for the wellbeing of the litigant who comes at times 'to the Judiciary to ask for a drug (s)he needs to survive'[696].

The identified internal factors were then reinforced by external factors which according to judges would contribute to them granting the health care claims. These external factors relate to the structure of Brazilian society and its institutional frameworks which have a bearing (even if not directly) on how actors, including legal actors, behave. The first external factor identified is closely related to the distrust in public institutions mentioned above and refers to a cultural constructed perception of Brazil as a country where public authorities use the public machinery for individual gains, instead of advancing sound public policies. Judges also referred to a second external, legal factor. Broadly phrased legal obligations would enable judicial activism to be exercised – even though judges did not refer to themselves as 'activist'. According to the interviewed judges, the law (and more specifically the Brazilian Constitution) permitted their intervention in health care cases as the Constitution provides for the universal right to health care as a fundamental right. As such, when deciding these cases, judges and courts would not be interfering with or disregarding the separation of power (i.e., being activist), but merely enforcing a constitutional command through judicial constitutional review. This interpretation of the law was often supported by reference to previous Supreme and Superior Court decisions

[696] Interviewee 16 (2016) Interview with first-degree judge in Rio de Janeiro (RJ) [07/12/2016]

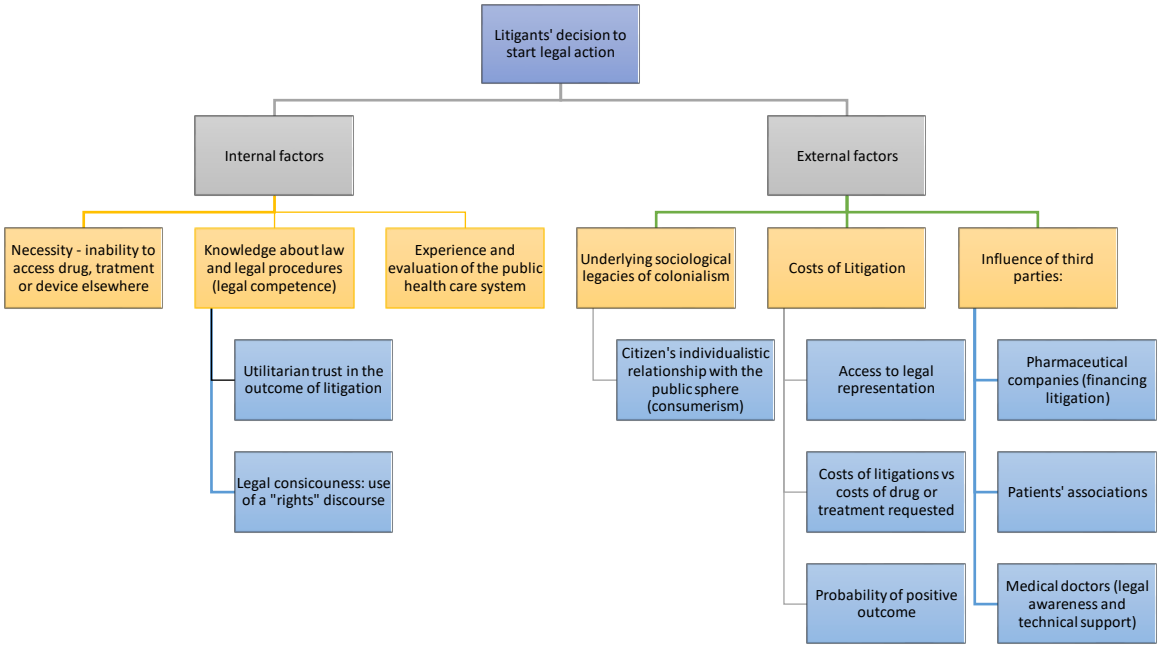
which declared that a judicial enforcement of the constitutional right to health does not infringe the separation of powers doctrine.

Nevertheless, some interviewed judges admitted knowing the detrimental impact health care litigation has on the system. For instance, the budgetary pressure it produces in the system, or the fact that it feeds into the interest of economic power such as pharmaceutical companies. Some judges also recognised that health care litigation permits citizens who *can* access legal advice to cut the queue of the public health care system – therefore widening inequalities.

By mentioning that the extensive interpretation given to the constitutional text is not necessarily applied to other socio-economic rights (such as education) or referring to the law as an instrumental tool which is used (or manoeuvred) to achieve a personal objective, judges, either directly or indirectly, admitted *using* the substantive constitutional law to give a quick fix to the individual case – what I refer to as a legal *jeitinho*.

The high rate of claims being granted then fuelled the litigants' expectations of accessing health care via litigation, incentivising further litigation..

FIGURE 14: SOCIO-LEGAL FACTORS THAT INFLUENCE LITIGANTS' DECISION TO START A LEGAL CLAIM



On the litigants' side, their perceptions of litigation and reasons for starting legal claims was of a much more utilitarian nature than those described by judges. Moreover, litigants mainly referred to their decision to start legal action as arising from the need to access the drug, treatment or device prescribed by their medical doctors, which could not be *easily* accessed elsewhere (i.e., in public hospitals or public pharmacies). The necessity to access health care services and drugs was then coupled with the litigants' awareness of the possibility of starting legal action (legal competence). Litigants gained such awareness either through their physician, social media, friends and family, or due to previous experience with litigation. Rarely did these litigants refer to the possibility of starting legal action in the form of a "rights discourse", by referring to their constitutional right to health care. The option of litigation was referred to instead merely as a viable option for accessing the drug, treatment or medical device prescribed by their doctors. The accounts provided by interviewed litigants reflected an utilitarian nature of trust in the Judiciary. They trusted the outcome of the litigation rather than the ethics of judges or a sense of justice arising from the procedure. This utilitarian calculation also

accounted for the access to legal representation, confidence in the outcome and overall limited costs of litigation, which was often mentioned as being much lower than the cost of buying the drug, which was in turn accompanied by a narrative of health care as an individual right (rather than a collective one) which should be offered at any costs, given the high taxes and levels of corruption observed in governments.

I interpret this individualised perception of right the health and use of the judicial system by litigants as a commodification of the public services, which feed into the development of a health care litigation industry that involves pharmaceutical companies, patients' associations and medical doctors. As the diagram illustrates, these third parties are presented as external drivers of the litigation phenomenon.

As mentioned, the framework illustrated in the two diagrams above, where factors are divided into external and internal, is used as an analytical tool. These factors intertwine and reinforce one-another, creating a complex socio-legal web. For example, the cultural and sociological factors, which are identified as external, and the perceptions of inefficient public policies and corrupt authorities, are often internalised by judges as distrust and feed into their perception of a situation of social injustice against citizen who need access to drug, treatment and medical devices. Their empathy towards the litigants and distrust of the Executive (internal factor) is then ignited by their sense of empowerment (internal factor) and by the legal tools at their disposal (external factor). The judges' decisions then feed into the litigants' expectations regarding litigation – i.e., how probable it is to win the claim - fuelling litigants' utilitarian trust, which in turn is facilitated by third parties (i.e., pharmaceutical companies that enable patients' associations to offer free legal services to patients). The more litigants bring their claims against SUS, the more judges have a perception that the system is failing, which further fuels their distrust.

Therefore, I identify trust as the central factor, not necessarily because trust was the word most spontaneously mentioned in the interviews, but because the context described by interviewees as allowing successful health care litigation to multiply, always involved an account of inefficiency in the health care policies, corrupt public officials and/or the lack of political will to improve citizen's access to a good quality health care system. In light of that context, all types of interviewees expressed that the health care policy and the Executive authorities could not be trusted, which in turn fed the need for of an activist Judiciary. According to several interviewees, including judges and a civil servant of ANVISA, if it would not be for the Judiciary, citizens would have nowhere to turn to when in need of good health care.

During the interviews I asked specifically whether interviewees thought distrust was a factor influencing the rise of health care litigation. 37 out of the 43 elite interviewees replied yes. Only one judge from the Superior Court of Justice was vehement to say that access to health care is a legal, constitutional matter, and when granting a drug or treatment not included in the public policy, the judge is merely enforcing the constitutional law, irrespective of their view of Brazilian politics. All other 'elite' actors, including the other 18 judges interviewed, explained that health care litigation is a phenomenon which transcends the formal law, and thus needs to be understood in the light of the sociological context of Brazil.

Therefore, the distrust externalised by the different actors in relation to their perception of the Brazilian health care policy, and public authorities in general, had different impacts depending on the type of actor. Moreover, in the case of litigants that was not central to the decision to start legal action but was mentioned when discussing health care litigation from a normative perspective – i.e., if they thought lawsuits were a correct and just way of accessing health care, to which many answered that it was a necessary evil *vis a vis* the bad quality of public governance and corruption. For judges, however, the distrust fuelled their own personal

responsibility to do something about a situation of injustice. It thus directly impacted the outcome of the lawsuit. This meant that due to their distrust in the public system, judges were far more willing to use the legal tools available to them to *personally* "fix" a perceived unjust situation. This action is what can be interpreted as an attenuate form of judicial activism.

9.2 Judicial activism from the ground-up: the importance of first-degree judges in health care litigation

Judicial activism is often a term interpreted in a pejorative way[697], referring to judges who want to expand the power of courts by invading the arena of other powers (such as the Legislature or the Executive). It is also often associated with judges who act politically[698] – i.e., to advance a political agenda. Maybe for that reason when questioned if judges in Brazil perceived their actions as activist, most were vehemently against such a label. According to the interviewed judges, when deciding to grant the lawsuits against the public health authorities, they were acting within the legal scope of a judicial constitutional review and enforcing a constitutional right against an illegal action (or omission) of the public power. As such, they did not see themselves as acting politically.

This refusal expressed by judges to be perceived as activist or as acting politically, although mentioning political reasons to grant their claims (i.e., bad quality government and corruption) illustrates an interesting, new account of judicial activism which is identified in health care claims in Brazil. Moreover, judges in Brazil present an *attenuated activism*, which can be explained as their willingness to grant access to health care in cases not authorised by

[697] Lino A GRAGLIA, 'It's not constitutionalism, it's judicial activism' (1996) 19 Harvard Journal of Law and Public Policy 293

[698] Kermit ROOSEVELT, *The myth of judicial activism: making sense of Supreme Court decisions* (Yale University Press 2006)

the health care policy, for political reasons (i.e., not trusting the ethics and competence of the public policy maker), while at the same time refusing to be seen as a political actor.

Furthermore, another important facet of this *attenuated judicial activism* in Brazil, is the seminal importance of the individual, first-degree judge. Whilst most accounts of judicial activism in the literature focus on higher courts (especially Supreme and Constitutional courts), what I identify in my research is the importance of lower court judges in fulfilling this bottom-up activism. First degree judges have a more personal contact with parties, and a closer connection to the facts involved in the claim. Therefore, these judges express a higher degree of pressure arising from an empathy for the litigants. Furthermore, judges in small cities, are often the only ones in their jurisdiction, and as such feel more responsible for the lives of the citizens. Under such conditions, judges in lower courts are prone to activism, exercised in the individual cases put before them.

The legal power of lower courts judges is not weaker, however. In a system where constitutional control can be done by any judge in the country, such as in Brazil and in Colombia through the *tutelas*, each judge is able to impact their localities through each individual claim.

By using a constitutional narrative to fix a sociological and political problem, judges find a way around the law to address the perceived systemic problems. This is what I identify as a legal *jeitinho* in the health care litigation phenomenon in Brazil.

9.3 A legal *jeitinho* around a systemic problem: using the legal to address the socio-legal

Beyond a legal issue, health care litigation in Brazil can be also understood as a result of the historical development of a Brazilian society which, since its colonial roots, distrusts the public institutions. A society which sees in its political elite a patrimonialist group who is unwilling to serve the larger population. As a consequence of this culturally constructed notion

that Brazilians cannot rely on public authorities, when in need, Brazilians seek a creative way around the formal structures – a cultural trace which was called by anthropologist Roberto da Matta as the *jeitinho brasileiro*. In the case of health care, when unable to access the drug, treatment or medical device, the way around a perceived inefficient and bureaucratic machinery is litigation. In turn, judges, faced with the situation of a litigant who is in need of medical help, and imbued of the same socially constructed distrust in the public authority, is driven to grant the claim against the State. Because (s)he has the legal power to do so and feels like in such a way they are correcting a social injustice.

In such a light, health care litigation in Brazil can be understood as another expression of the *jeitinho brasileiro.* In other words, the use of mass-individual litigation and judicial decisions as a method of granting drugs/treatments not covered by the public health care system can be framed as a *jeitinho,* a quick fix to solve, in the individual sphere, a problem which is systemic in nature. Litigation is a way 'around a problem' which should be solved by the public health care policymaker and by politicians.

By using the theory of Roberto Da Matta to explain the *jeitinho*, I identify the use of judicial decisions in individual claims as a systematic form of accessing drugs and treatments not covered by the public health care system, as both an exercise of the flexibility/creativity of Brazilians, and a rebellious practice. It is a form of creativity insofar as it escapes the perceived constraints of the system – a bureaucratic, corrupt political environment - to solve a concrete problem – the citizen's need for a medicine or treatment. But it can also be framed as a rebellious movement of judges who, even though conscious about the negative implication of health care litigation for the public policy and administration (i.e., referring to the burden of judicial decisions on the public budget and the development of a health care litigation market), still grant the requests *because* of their lack of trust in the system.

It is important to remember that, as the anthropologist Roberto Da Matta points out, the *jeitinho* must not be mistaken for corruption or taken as a *necessarily* wrong or immoral behaviour. The *jeitinho* can also be a creative manner of navigating rough institutional waters. A bending of formal procedures to correct imbalances in power and providing compensation for unjust scenarios. In the case of health care litigation, some judges and other actors, such as public defenders and prosecutors, *believe* that judicial decisions, even if resulting from individual claims, and even if disrupting the public policy, are the best way to correct the current scenario in Brazil, where millions of citizens are denied access to a quality health care whilst a few others - like judges themselves - have access to one of the best private health care systems in Latin America. Some also think it is *the only* way around a systemic problem of corruption and inefficient public institutions.

As said before, the goal of this thesis is not to provide a normative analysis of health care litigation, but to develop an explanatory, middle-range theory of the socio-legal factors which contribute to an increase of successful health care claims in Brazil. It must be stressed, however, that in the same manner that *jeitinho* is described by the literature as a complex phenomenon of creatively working around (or with[699]) the law, and sometimes breaking the law, to achieve a desired result in a response to an unjust system, so can the decision of judges to grant health care claims be understood in such a multifaceted lens. On the one hand, the health care litigation produces inequalities and destabilises the public health care system[700], a fact which is known and acknowledge by several judges – as explored in Chapters 4 and 5. On the other hand, it is understood by many as a legal way around an unjust and inefficient system. Several judges *perceive* their actions as way to respond to the systemic injustice, inequality, and inefficiency. To do so, however, judges *manoeuvre* the constitutional law by broadly

[699] EWICK and SILBEY, *The Commonplace of law. Stories of everyday Life*
[700] FERRAZ, 'Harming the poor through social rights litigation: lessons from Brazil'

interpreting the concept of *universality and integrality* of the health care system provided for in articles 196 and 198, II, of the Brazilian Constitution. And, in hindsight, after deciding the result they wish to obtain – i.e., grant the drugs, treatment and medication – use the constitutional law to justify doing so. Some judges expressly mentioned that the massification of health care litigation is *wrong*, that it feeds into the economic interest of pharmaceutical companies, enables fraud, and cuts the queue to those who can access the judicial system. However, they also refer to that as being the only way in a country where public institutions cannot be trusted – a necessary evil. Similarly, judges also mentioned *using* the vagueness of the constitutional law to achieve the desired result of granting access to drugs and treatments not provided in the health care system – a legal manoeuver which was not applied in other socio-economic litigation, such as accessed to education ('creche'). This discrepancy was explained by some as lack of personal identification – i.e., judges could not see themselves in a position where they would need a vacancy in public schools for their children, whilst they could see themselves in need of a very expensive health treatment not offered by SUS or their private insurances. Understanding that would require further research comparing other types of litigation.

The health care litigation, and judge's decision-making about it, is a multifaceted phenomenon that cannot be oversimplified. It is certainly a dysfunctional legal solution to administrative problems, and as such requires urgent and more efficient alternatives. However, both litigants and judges' decisions in this phenomenon are not inherently bad or good. Whilst they are informed by *perceptions* of injustice, by an individual empowerment, and a sense of urgency and need, which could render them as justifiable, they are also part of a disregard of the public good, an excessive individualism which commodified the health and judicial systems and widens inequality. It is a use or manoeuvre of the law to achieve a desired result – a *jeitinho brasileiro,* with all its complexities.

9.4 Third parties backseat driving: the development of a health litigation industry

Whilst judges and litigants find a way (*jeitinho*) to achieve a desired outcome and work around perceived social-injustices via health care litigation, a strong economic force is back-wheel driving the phenomenon. Although judges and litigants are central actors in the mass health care litigation phenomenon in Brazil, the high volumes of litigation and high rates of success incentivised the development of a market, which involves in particular private lawyers, patients' association who seek litigants and pharmaceutical companies who finance litigation indirectly by donating to patients' associations.

The economic interest of pharmaceutical companies and patients' associations in health care litigation, in turn, influences the occurrence and outcome of the lawsuits, insofar as they finance the development of a structure that enables the multiplication of individual lawsuits aiming to get access to drugs or treatments not included in the health care public policy. It is worth noting that Brazil does not have laws regulating litigation third party funding (TPF)[701], even though the economic influence of pharmaceuticals in health care cases in Brazil is indirect.

Furthermore, the medical doctors are important players in the phenomenon, figuring as an essential source of information about litigation to patients, as well as sources for the technical documents which substantiate the burden of proof for the lawsuit.

The interviews with representatives of the pharmaceutical industry, of patients' associations and medical doctors shed light on how the pharmaceutical companies and associations that operate in the litigation phenomenon, and how these actors understand the

[701] The discussion of TPFs in Brazil is still embryonic in comparison with the efforts to prohibit or regulate it in Australia, Canada, US and the UK, for instance (Jasminka KALAJDZIC, Peter CASHMAN and Alana LONGMOORE, 'Justice for Profit: A Comparative Analysis of Australian, Canadian and US Third Party Litigation Funding' (2013) 61 The American Journal of Comparative Law 93 and Victoria SHANNON, 'Recent Developments in Third-Party Funding' (2013) 30 Journal of International Arbitration).

right to health care and access to health care via litigation. These interviews confirmed the presence of distrust, individualism and commodification further discussed in chapter 7.

Through the interviews with these "third parties" I was also able to understand why health care litigation in Brazil is *not* mainly done via collective litigation. Whilst some representatives of patients' associations did not know that they could file collective actions representing the interest of all patients suffering from a particular disease, other interviewees explained that getting a successful outcome out of a collective action is much harder and slower than through individual claims. Thus, by observing the outcomes of other collective claims, lawyers, and the pharmaceutical companies and associations which often paid for their legal services, conclude that "retail litigation" – on a case-by-case basis – is more efficient than litigating collectively. Although this perception does not necessarily reflect the success rates of collective litigation versus individual ones (which instead have similar success rates, according to the research conducted by Insper[702]), by *perceiving* individual litigation as more successful, these actors continue to incentivise it by offering free legal services to individual litigants, and actively seeking patients to start legal action.

The power of pharmaceutical companies to finance litigation is one important driver for the astounding multiplication of health care claims in Brazil, and is interestingly indirectly assisted by the willingness of judges to grant the individual claims.

9.5 Contribution to the literature

The primary goal of my socio-legal, qualitative study of litigation for access to health care in Brazil was to develop a middle-range grounded theory, as depicted in the diagrams

[702] DE AZEVEDO, ABUJAMRA and ALL, *Judicialização da Saúde no Brasil: Perfil das Demandas, Causas e Propostas de Solução*

above which maps and identifies relationships between different socio-legal factors as drivers of successful health care litigation. Furthermore, I show how key sociological elements, most of which result from a past of colonialism, such as concentration of economic and political resources in the hands of the elites, clientelism, corruption, distrust, and the *jeitinho*, also drive the rise in successful health care lawsuits. These factors have a bearing not only on how/why lawsuits are started and decided, but more generally also flow from how Brazilians relate to the public sphere, what they expect from the State and public authorities and how the relationship between public institutions operates. Therefore, the middle-range theory is my main contribution to the literature on health care litigation in Brazil, and to the overarching discussion of access to health care via courts in other countries which experience similar phenomena and have similar social structures (i.e., India, South Africa, Costa-Rica and Colombia).

However, the themes explored within the context of health care litigation in Brazil also shed light on other discussions in the legal and socio-legal literatures. Therefore, my findings also contribute to the following overarching topics of legal and socio-legal literatures: (i) judicial activism and judicial empowerment; (ii) trust and inter-institutional relationships; (iii) judicialisation of politics; (iv) access to socio-economic rights through litigation; and, more broadly, (v) judicial decision-making.

Although the proposed middle-range theory developed in this research about the linked social-legal factors underpinning health care litigation arises from the localised observation of the Brazilian experience, some of the middle-range theory conclusions, such as the importance of trust and perceptions of quality of government in influencing the outcome of litigation, be extrapolated and tested in other jurisdictions which show similar occurrences of judicialising the access to health care, and that share colonial pasts similar to that of Brazil. As discussed in Chapter 8, many other countries, such as India, South Africa, Costa-Rica and Colombia present

also an increase in the number of litigations for access to health care[703]. In Colombia, a generalised distrust in public institutions and dissatisfaction with the public health care system, aligned with an increasing judicial power and easy access to constitutional litigation (via *tutelas*) have also resulted in high numbers of successful health care litigation in the country.

Furthermore, I was able to unpack how the Brazilian case – similar to what took place in Colombia[704] – displays a judicial activism which is mostly centred around individual judges. Whilst the main legal and behaviourist literatures, both in relation to Brazil and Colombia, focus on how judges of Supreme and Constitutional courts decide and how much bearing their political opinions have on their judicial decisions, there is a high level of judicial activism in lower courts and individual judges – even in collegiate courts, a substantive number of decisions is granted by individual judges publishing their individual judicial ruling (monocratically).

Judges in the first-degree courts feel empowered to decide the cases according to their own interpretation of the constitutional law, manoeuvring the law in order to achieve a *perceived* social justice. This empowerment comes from their understanding of the role a judge plays in the Brazilian society, which, in turn, is a reflex of the historical post-colonial development of an unequal society where the majority does not have access to the same high-quality health care enjoyed by the richest (including judges), and where public authority, particularly lawyers, hold a substantial degree of institutional power and freedom to act independently of political pressures. The literature about Colombia would gain from an in-depth understanding of how lower court judges understand their role in the Colombia society.

[703] YOUNG and LEMAITRE, 'The comparative fortunes of the right to health: Two tales of justiciability in Colombia and South Africa'; Everaldo LAMPREA, 'The Judicialization of Health Care: a global south perspective' (2017) 13 Annual Review of Law and Social Science 431

[704] YAMIN and PARRA-VERA, 'Judicial protection of the right to health in Colombia: From social demands to individual claims to public debates'

In relation to trust, as described above, I presented two very different accounts of it, both essential to the outcome of successful health care litigation: one in relation to judges, who display a lack of trust in the good will, technical competency of the government, and the second in relation to litigants, who understand trust in the Judiciary as related to the probability of successful outcomes from the lawsuit. These different accounts of trust help to illustrate why the concept needs to be understood within the context of a wider typology of different types of trust, which I present in chapter 4. While the (dis)trust portrayed by judges referred to a moral and subjective analysis of the trustworthiness of the Executive, the trust mentioned by litigants was utilitarian in nature. Therefore, albeit an essential factor in the decision-making process of both groups, the nature of trusts in the different cases varied significantly, which indicates that comparisons, such as the ones proposed by indexes measuring trust in institutions, can be deceptive.

Another contribution of my dissertation is to the literature that discusses the use of a rights-based constitutional narrative as a legal tool for the enforcement of socio-economic rights via litigation. By examining how Brazilian judges use and interpret the constitutional law to justify their published judicial decisions, in contrast to the socio-legal factors presented during their interviews, I analyse how the formal law dialogues with such factors. Furthermore, I question how judicial decisions which can be often personal and political in nature are formally justified with reference to the use of constitutional law. By focusing on how the constitutionalisation of rights and the rights narrative serve as a hindsight justification for judicial activity, I offer an explanation of the role the formal law plays in the socio-legal phenomenon of health care litigation. My argument is that the constitutional law is used by Brazilian judges in hindsight, hiding important issues such as corruption, inefficiency of the public policies, and bad use of public resources, which in turn are central factors for their

decision-making. In this way, the constitutional law is used as a *jeitinho* to go around a perceived 'bad' government (with the law[705]).

Furthermore, by exploring the internal and external factors brought up by judges during interview as drivers of their decision to grant health care claims, I could highlight the importance of certain emotions, such as empathy and altruism, in feeding judges' disposition to grant access to health care. By also including 19 first-degree judges, I found out the importance of individual adjudicators at all levels to shaping the law, and in turn the importance of understanding the context in which each judge is embedded to understand his/her decision (Chapters 4 and 5).

Finally, some of the analytical conclusions arising from the case study of the massification of health care litigation in Brazil can be extrapolated to the wider context of the judicialisation of other socio-economic rights, such as education and sanitation though subject to the qualifications referred to above. Moreover, the judicial review of administrative decisions regulating other socio-economic rights involve similar legal discussions about the realisation of fundamental socio-economic in light of the Brazilian social structure and institutional framework. However, they do not necessarily happen under the same conditions – i.e., the presence of a strong economic force such as pharmaceutical companies. Therefore, by comparing and contrasting litigation of other socio-economic rights with litigation for access to health care we can find empirical insights into the relative significance of factors identified in this research and other potential socio-legal factors not yet identified and examined.

I leave, therefore, an open door for further research which can pick up from the findings of this thesis to understand if and in what way the web of factors identified here is applicable

[705] Patricia EWICK and Susan S SILBEY, *The common place of law: Stories from everyday life* (University of Chicago Press 1998)

in different cases (i.e., other social-economic rights) or other jurisdictions (comparative studies).

9.6 Future Research: expanding the socio-legal understanding of social-economic rights litigation

As a complex phenomenon, health care litigation is a fruitful field of academic research, particularly in socio-legal studies. As mentioned above, the socio-legal literature in the field is still not widely developed, and there are still many questions to be answered. Here I touch upon three potential areas of research that could be developed from the findings of this thesis.

The first addresses comparative analysis. As I explained throughout this research, and more specifically in Chapter 9, the goal of this thesis was to develop an in-depth socio-legal analysis of socio-legal factors that can help to explain a significant increase in litigation and successful health care claims in Brazil. However, mass litigation for access to health care is a phenomenon observed also in many other countries, such as Colombia (analysed briefly in Chapter 9), Argentina, Costa Rica, South Africa and India – to name a few. Similarly to Brazil, these countries were also the object of extensive legal research about health care litigation, but there is still little understanding of how socio-legal factors such as the ones analysed in this thesis operate in the context of these countries. The literature about health care litigation, access to social-economic rights via courts and judicial empowerment would be enriched from an in-depth understanding of what other non-legal factors influence judicial decision making in other countries – i.e., is distrust in the government and/or public policy a factor informing judge's decision in judicial review also in these countries? Is there a component of empathy and self-empowerment in judicial decision-making in cases seeking access to health care? How do the different experiences of colonialism, as well as racial and caste segregation in these countries matter, if at all?

Furthermore, a contrast analysis of countries where judicial restraint is observed in cases of access to health care could also contribute to a wider socio-legal understanding of how, for example, trust in public institutions plays out in judicial decision-making. In that sense, further research could involve interviewing judges in the United Kingdom to understand why they exercise a higher degree of deference towards the technical decisions taken by the Secretary of State for Health and Social Care and NHS trusts.

A second angle for further research in the field would entail comparing the case of health care litigation with litigation of other social-economic rights. For example, in Brazil courts have been observing a higher number of successful claims requesting access to education – also a fundamental right provided for in the Brazilian Constitution – but not at the levels observed in the case of health care. Other social-economic rights, such as sanitation, for example, do not seem to generate the same numbers or positive outcomes of health care claims. Why is this so? Is the interest of a powerful economic player – the pharmaceutical industry – that makes the key difference here? Or are judges more prone to granting cases requesting access to health care for an emotional reason – i.e., the burden of deciding a health case?

Such a thematic comparative analysis would enable a broader understanding of the drivers behind litigation for social-economic rights, and the factors influencing judicial decision making across various jurisdictions.

Finally, a further research proposal would be to assess how to address the mass health care litigation phenomenon in Brazil and other countries. What could be done about it? To answer this question, future research would need to assess two different elements. Firstly, still with reference to litigation, how to incentivise the reduction of individual litigation and focus on strategic, collective claims which could address the systemic problems identified by judges – lack of administrative efficiency in the administration of health care and transparency. In this regard, Brazil already has the procedural tools necessary to enable such litigation, both as

collective claims and representative cases. Therefore, future research could look at how these procedural tools could be used to efficiently contribute to a healthy public policy. The second element would be looking at how to de-judicialise issues involving access to health care. This approach would look at alternative methods which could give citizens an effective channel of complaint in substitution for judicial litigation. For example, this research could look at ombudsman initiatives and administrative procedures, such as internal appeals for citizens to request access to drugs, treatment and medical devices not available through the SUS.

There are numerous angles from which to look at this important socio-legal phenomenon of an increase in successful claims for access to health care, and important outcomes regarding the relationship between courts, the Executive and citizens. The dynamics of litigation, especially judicial review, showcase issues which are central to a country's democracy, and should be understood from all of its complex interwoven aspects. Socio-legal research provides the opportunity to bridge the gaps often left by legal research and highlight the importance of understanding the sociological and historical context and the individuals, such as lower degree judges, as well as individual litigants, behind legal phenomena.

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ANNEX 1 – SEMI-STRUCTURED INTERVIEW QUESTIONNAIRE

(All interviews were conducted in Portuguese – these questionnaires served as a basis, questions were not necessarily made in this order and other follow-up questions were asked depending on the interviewee's responses)

LITIGANTS

1. Please describe to me your experience with health care litigation. What kind of treatment/medication did you seek?

2. Why couldn't get the medication through SUS? Did you ask for it in the Secretary of Health (administrative process)?

3. How did you find out that litigating was an option? Who advised you to seek the courts?

4. Tell me how was that process of litigating, from finding a lawyer to filing the case etc)? How much did it cost?

5. What were the factors you considered when deciding to litigate?
    a. How about the costs of litigation?
    b. Time? Bureaucracy?
    c. Have you considered the public defender's office?

6. Was trust in the judiciary a factor in deciding to start legal actions?
    a. What kind of trust is that?

6. Have you litigated previously?
    b. Has the outcome of that litigation influenced your decision to litigate this time?

7. Did the judge grant you the medication/treatment?
    a. Did you receive right away?

8. Would you litigate again should you need?
    a. Do you think the outcome of your litigation would influence your decision to litigate again?

9. The Supreme Court is debating restricting the type and reach of decisions judges can grant in health care. What do you think about that?

10. Do you think you would go to the judiciary if you knew judges were not granting as much anymore?

11. Some believe that the distribution of medication and treatments (especially high costs ones) through litigation increases inequality in the access to health care. What do you think about that?

JUDGES

1. What do you think enabled litigation of health in Brazil to reach this proportion?
2. Do you usually grant access to medication/treatments? In which cases?
    a. Why?
    b. What about high-cost drugs? And medical devices such as acupuncture, pilates, Viagra?
    c. Do request any conditions to granting medication/treatment (ex. Low income or non-experimental drugs)?

3. Do you think by granting medications/treatments judges are influencing public policy?
    a. Is that the role of the judiciary? Or should it be left to the Executive?
    b. Is there a degree of self-empowerment?
    c. Is it judicial activism?

4. Do you think there is an element of distrust in the administration?
    a. Is there unawareness regarding the technical procedure to accept a medication on the SUS list?
5. Do emotions influence your decision-making? In what way?

6. Does the high success rate of health care claims incentivise more litigation?
    a. Why do you think people decide to litigate?
    b. Is there a component of trust in the judiciary?
7. Why aren't there more collective claims or IRDR?

8. How important are the other actors in the health care litigation (associations, lawyers, pharmaceutical companies)?
    a. Are they benefiting from this phenomenon?

9. Part of the criticism towards health care litigation is that it contributes to inequality in the system. Do you agree?
    a. What about incentivising frauds?

JUSTICES (Supreme Court and Superior Court of Justice)

1. What do you think enabled litigation of health in Brazil to reach this proportion?

2. Why do you think judges grant requests for medication? Do you? Why?
    a. What about high cost drugs? And medical devices such as acupuncture, pilates, Viagra?
    b. Should there be limits to what judges can grant?
    c. Should there be conditions to granting medication/treatment?

3. Do you think there is an empowerment of the judges in health care litigation?

4. Is there a lack of deference to the decision of the administration (ANVISA, Conitec)?
    a. Is there unawareness regarding the administrative procedure?

5. Do you think that lack of trust in the Executive influence judge's decisions?
    a. Is this judicial activism?

6. Do you think emotions factor into the decisions?

7. Does this litigation phenomenon create an unbalance of Powers in Brazil?

8. Are judges in Brazil interfering in Health Care policy?
    a. Should that be left to the Executive?

9. Does the large number of decisions granting litigation incentivise more litigation?

10. Why do you think people decide to start legal action?

11. Is there a component of trust in the judiciary?

12. Why aren't there more collective claims or IRDR?

13. How important are the other actors in the health care litigation (associations, lawyers, pharmaceutical companies)?

14. Are they benefiting economically from this phenomenon?

15. Part of the criticism towards health care litigation is that it contributes to inequality in the system. Do you agree?
16. What about incentivising frauds

'THIRD ACTORS': PRIVATE LAWYERS, PUBLIC DEFENDERS, PROSECUTOR
(These questions were tailored to the case of each interviewee, and the institution they represented)

1. Why do you think health care litigation reach such proportions in Brazil?

2. Have you represented many litigants who requested medication/treatment via SUS in the judiciary?
    a. Who are usually your clients?
    b. How do your clients normally reach you – how do they become aware of litigation?
    c. Can you describe how you normally explain the procedures to your clients?

3. What is your rate of success?
    a. Do you present this to your clients?

4. Why do you think people litigate?
    a. Do you think there is an element of trust in the judiciary in the decision to litigate?

6. How are you usually remunerated in these cases?
    a. Do you offer probono?

7. What is your legal strategy?

8. Why do you think judges grant so many claims?

9. Do you think judges are being activists?
    a. Is this the role judges should be taking? Is there a breach of the separation of power?

10. Is there a lack of deference of judges to the decision of the administration?
    4a. Yes: why is that?
    4b. Do you think there is an element of distrust of judges in the administration?

11. Does the success rate incentivise more litigation?
    a. Does it incentivise frauds?

12. Are there any other economic powers influencing litigation – i.e., pharmaceutical companies?

13. Why aren't there more collective claims or IRDR? Have you ever used them?

14. The State claims that the distribution of medication and treatments (especially high costs ones) through litigation implies less money for basic health care and hospital maintenance for millions of people. What do you think about that?

OTHER THIRD ACTORS: PATIENT'S ASSOCIATIONS, PHARMACEUTICAL COMPANIES, CIVIL SERVANTS, MEDICAL DOCTORS

(these questions were tailored to the case of each interviewee, and the institution they represented)

1. Why do you think health care litigation reach such proportions in Brazil?

2. Can you describe your role? How does your institution relate to health care litigation? Do you refer people to litigation or help them litigate?

3. Why do you think people litigate?
   a. Do you think there is an element of trust in the judiciary in the decision to litigate?

4. Why do you think judges grant so many claims?

5. Do you think judges are being activists?
   a. Is this the role judges should be taking? Is there a breach of the separation of power?

6. Is there a lack of deference of judges to the decision of the administration?
   6a. Yes: why is that?
   6b. Do you think there is an element of distrust of judges in the administration?

7. Does the success rate incentivise more litigation?
   a. Does it incentivise frauds?

8. Are pharmaceutical companies influencing litigation?

9. Why aren't there more collective claims or IRDR?

10. The State claims that the distribution of medication and treatments (especially high costs ones) through litigation implies less money for basic health care and hospital maintenance for millions of people. What do you think about that?